Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33501 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 18, 2011 8:20 A M Lisa Suzanne Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Senator Bob Hooper House Harford Forest Hill Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Min. Director 214-76-2427 1 M 2 XF Maryland 52 Mar. 5, 1959 Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Harford Forest Hill 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 2416 Rocks Road 21050 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. g 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White 105ch 18,201 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Owner/Operator Chiropractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Eugene Brown Edith Ann Beer Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Christine St. Ours / Sister 916 Mine Branch Road, Street, MD 21154 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Service Corp. 10-20-11 Towson, Maryland ²² Name and Address of Facility MCComas Funeral Home, P.A. 21. Signatur f Funer Service Liger 1317 Cokesbury Road, MD 21009 Abingdon, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Physician Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 TYes 2 No Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy perforn After this certificate has Hospital or Attending Physician: The 25. Was case referred to medical 26. Place of Death (Check only one. Be examiner? Other: 4 Nursing Home 5 Residence 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury Natural 5 \square Pending 2 ccident 1 Tyes 2 | No Investigation 24 hours after death Funeral Director completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 30. Name and a 2300

DHMH 17 Rev 06-2011

State

Registrar

21

OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11:15 A M Physician/ Brewer 16tricin 10 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Bel Air 3112 Nova Scotia Road g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) 5. Social Security Numbe **Funeral** Month, Day, Year)
June 27, 1934 Maryland Months Days Hours 1 □ M 2 🔽 F Director 215-32-4655 Usual Residence of Decedent 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location Director 1 Yes 2X No Maryland | Somerset Deal Island 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA Page 1 and 2 should be filed within 72 hours after death with 21821 9810 Crowell Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?

1 Yes 2 XNo 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. If Yes, Give 3 ☐ Widowed 4 ☐ Divorced White "natural", Completed Year or Dates the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hazel Jean MacAuley Edgar Maurice Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3112 Nova Scotia Road, Bel Air, MD 21015 Cheryl A. Foley-Vail/ Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 X Cremation 3 Removal from State 10-19-2011 Towson, Maryland Hilltop Service Corp. 4 Donation 5 Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician weeks drahon disease or condition Due to (as a consequence of): Medical resulting in death) **Examiner** halla Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine to or as a consequence of) burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery use 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month in the past 12 months?
1 Yes 2 No ρ Pregnant at time of death 9 Unknown been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause o death? s certificate has b lirector, page 2 s performed? 2 🗌 No CAD 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Daughter examiner? Hospital Other 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specific this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

only one)

30. Name and address

29b. Signature and title of certifie

Kloesz 5701 Kenwood 31. Date filed (Menth, Day, Year) 32 Registrar's Signature OCT 2 1 201

of person who c

completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

21206

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $^{\text{Day}} 18,2011$ October JEFFREY LYNN BRINK 4:00p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Baltimore Co. Towson Social Security Number 7. Age (In yrs. last birthday) 1 Year | If Under 24 Hrs. Days | Hours | Min. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months (Month, Day, Year) 220-82-3969 **Director** 1 🕅 M 2 🗆 F 50 Yrs. 8-25-1961 Wisconsin Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No N/ABaltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 5208 Wright Avenue 21205 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Bus Driver Tourism Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic to Donald Edward Brink, Sr. Lillian M. Bortle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5208 Wright Avenue Baltimore, MD 21205 Robin Kriscumas/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Dremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory: 10-19-11 Baltimore, MD 22. Name and Address of Facility Kaczorowski Funeral Home, PA le 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death SOPHAGEAL Physician/ disease or condition MONTH Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending hybicidian and signed by the attending physician and debt be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 2 No 1 ☐ Yes 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 HNo 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. / 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, 220p M Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner as a ear If Under 24 Hrs ce (State or Foreign 8. Date of Birth (Month, Day, Jan 4, 9. Birthpla 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 M 2 X F 1926 Costa Rice 092-48-5304 85 Director Usual Residence of Decedent 10d. Inside City Limits 23a or 28a-f show 10b. County 10c. City, Town or Location 10a. State Medical Examiner must be notified at Director 1 ☐ Yes 2√☐ No Hagerstown MD Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Costa Rica 21742 14014 Marsh Pike items 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces? 1 Yes 2 No Black, White, etc. or 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. black If Yes, Give Year or Dates "natural", 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Department of health and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic event, the Meonee. Elementary/Seconday (0-12) College (1-4 or 5+) education 12 teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Hortence Flowers Solomon Clarke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 11404 Stonecroft Court #308 Hagerstown, MD 21742 Dulceta Clarke/sister in law 20c Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Statem With the Board 655 W. Baltimore Street Kon 11 Wade 21201 Baltimore, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death heime Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of) the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death for use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Yes 2 No Month Day Pregnant at time of death been signed by the should be detached Unknown Part II., Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No has 1 Yes 2 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? Hospital Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes this funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death I Director: After to in by the funeral injury Natural 5 Pending 1 🗌 Yes 2 🗌 No within 24 hours after death. To the Funeral Director: A Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

OCT

Name and address of person who completed

21

201

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State Registrar Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

32. Registrar's Signature

OCME

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 19,2011 Physician/ 10:09P M John Cucchiella Joseph Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Carroll Westminster 8. Date of Birth (Month, Day, Year April 24, 1 Social Security Number 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 XM 2 - F Hours 217-20-5124 Director 83 Usual Residence of Decedent items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carroll Co. Westminster 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Completed by Funeral 505 High Acres Drive, Apt 224 United States of America permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? 1 X Yes 2 □ No Black, White, etc. or. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 🗌 Widowed 4 🗌 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Bugle Line Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Sales Person 12 Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Bernadino Cucchiella Florence Vigna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .s Health a Edna Cucchiella - Wife 505 High Acres Drive, Apt 224, Westminster, Maryland 21157 mportant: If item 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Nation 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Oct. 24, 2011 Baltimore, Maryland Most Holy Redeemer Cem. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road, Parkville, Maryland 21234 -Parkville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Certificate: To Be Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 🗌 Yes ul or Attending Physician: ⁷ s after death. I Director: After this certifici Division of Vital filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗷 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur d title of certifier 29d, Date signed (Month, Day, Year) of death (Item 93a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Valentin J<u>ohn Cruz, Jr</u> 2011 25 PM Medical 13 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLin Square Hospital Baltimore osedale 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 M 2 🗆 F Months Days Min. Hours Director 63 Yrs 134-38-4341 New York May 03, 1948 New York Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 Yes 2 No 10e, Street and Number or 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral with 1 1212 3rd Road 21220 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Completed 3 ☐ Widowed 4 🔀 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wil
Department of Health and Mental Hygie.
Important: If item 27 is marked other t
any injury or other trees. Cable Contractor Construction Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Valentin John Cruz, Sr. Anna Margaret DeHaven 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki Copp- (Fiance) 1212 3rd Road Middle River, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State October 20, 4 Donation 5 Other (Specify) Evans Funeral Chapel—Bel 2011 Forest Hill, Maryland 22. Name and Addre Facility Evans Funeral Chapel & Cremation Services-Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ Metastic disease or condition Lung cancer Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Venous Thromboembolism 1 Yes 2 No 3 Probably 4 Unknown Completed Dermato myositis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Anemia performed' 2 🗌 No Yes 2 A Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: P 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending injury 1 Yes 2 No Investigation the Funeral Director: npleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number

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DHMH 17 Rev 7/2009

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Shinner

DANIELL

31. Date filed (Month, Day, Year)

005369

4000 FRANKLIN Square DR Balto mod 2123

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 17, 2011 Susan Michele Cowan 6:15 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8866 Wellbeck Way Montgomery Village Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, May 19, cial Security Number 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Ohio 1969 **Director** 298-74-0435 42 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Montgomery Village 10e. Street and Number 10f. Zip Cod 10g. Citizen of What Country? Funeral 8866 Wellbeck Way 20886 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Specify: Latino Completed 3 Widowed 4 Divorced Year or Dates (unk) permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any injury or other traumatic event, the Medifical any injury or other traumatic event, the Medifical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Paralegal Law Firm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Emanuel C. Cowan Barbara A. Hardwick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phillip Hill/husband 8866 Wellbeck Way Montgomery Village, MD 20886 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Final Journey Crematory 10/19/11 Woodbine, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part 1. Enter the 1/ ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a. Congestive Heart Failure
Due to (or as a consequence of): disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi): that the death certificate be executed Cause (Disease or linjury that initiated events and-tran Due to (or as a consequence of) resulting in death) Last burial nding physician use as the burial Physician/Medical 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant Box 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No ed by the a g 🗍 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **À** Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Cholecystitis 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has k page performed? death? Yes 2 😾 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner' Hospital Other: 1 🗌 Yes 2 XNo ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) XNatural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in rry opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 18, 2011 D37142 son who completed cause of death (Item 232) (Type, Print) Geoffrey Coleman, 6001 Muncaster Mill Rd. Rockville, MD 20855 M.D

Registrar
DHMH 17 Rev 7/2009

State

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast 2. Date of Death 3. Time of Death 2<u>011</u> Physician/ Oct 3:10P Georgia C. Christian 19 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll . Social Security Number Country) Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Months Days Hours Min. 2-15-1936 213-32-1254 75 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits be notified at **Funeral Director** MD Carroll Westminster Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 415 Kingsbury Way, Apt. 31 21157 Examiner must USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Service Beautician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Asa E. Cassell Virgia McLaughlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Knorr-daughter 374 Buckingham Way, Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crem 10-23-11 Sykesville, MD 21. Signatur 90/Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home lillen Kones Z 21157 254 E. Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Stroke Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hypertension Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 monti Month Day Vear Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypothyrodism, Depression, Osteopenia 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No death? 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 abla Other (Specify) Dove 1 🗌 Yes မ 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred House 1X Natural injury al Director: Aftr 5 Pending 1 Yes 2 No Investigation 6 Could not be 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completed file Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0065246 10/20/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster, MD 21157 Nilar U 912 Washington Rd 31. Date filed (Month, Day, Year) State OCT 21

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Chapman Patricia Ann 1200 AM 10 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital of Baltimore Baltimore City 7. Age (In yrs. last birthday) If Under If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Months Hours (Month, Day, Year) 212-34-2998 Director 09 MD Chapman Usual Residence of Decedent 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director Baltimore 28a-f 1X Yes 2 ☐ No MD 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or important: If item 27 is marked other than "natural", or items 25a or ampring or other traumatic event, the Medical Examiner must be a once. Funeral U.S.A. 21207 5315 Norwood Ave 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black If Yes, Give 3 🗆 Widowed 4 🙀 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Mayors Office Of College (1-4 or 5+)
4yrs Elementary/Seconday (0-12) KNOWN AS Director Employment Services 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Clara Chase Milford Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2607 Claybrooke Drive, Baltimore, Md 21244 Myra Harris-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Date cemetery, crematory or other place) Donation 5 Cher (Specify) Memorial Park 10/21/2011 Woodlawn, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility. 21215 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration disease or condition resulting in death) pneumonia 15 days Medical Due to (or as a consequence of) Examiner 1 day Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): ending physician use as the burial Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter for u in the past 12 months? Pregnant at time of death Month Day Year 5 Other (specify) Yes 2 No n signed by the a ld be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Multiple scherosis, cerebrovascular disease, chronic Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an obstructive pulmonary disease To the Hospital or Attending Physician: The law certificate has autopsy performed Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Nnpatient 2 ER/Outpatient 3 DOA မ After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending death. 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director,
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Coli MD KES-000 October 16, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Huspital of Elliott MD.

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6:00 a October 2011 Constantine Calos Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 3203 Meadow Valley Dr. Abingdon . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 9/10/1923 Director 191-18-5539 88 Greece 1 X M 2 F 28a-f shov aţ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-1 si ner must be notified 1 🗌 Yes 2 🙀 No MD Harford Abingdon and 2 should be filed within 72 hours after death with the I Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21009 USA 3203 Meadow Valley Dr. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. event, the Medical Examiner Armed Forces?
1 X Yes 2 □ No Black, White, etc. 9 1 Never Married 2x Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Completed 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Self Employeed Master Plumber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Vasiliki Diacumakos Anthony Calos traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Forest Hill, MD 21050 Anthony Calos-Son 2226 Warfield Dr. or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important; If ite any injury or ot cemetery, crematory or other place)

Greek Orthodox Cem. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/22/11 Batlimore, MD 22. Name and Address of Facility 610 W. MacPhail Rd BelAir, MD Schimunek Funeral Home of Bel Air 210 Scrature of Funeral Service Licensee 21014 Part 1. Enter the disease, or complications that caused the pleath. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a co as the burial-trai Due to (or as a coverquence of): resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be after death.

Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? performe 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi 29a. Certifier (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 1708 3 32 egistrar's Signature

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 18,2011 Ferdinand Reese Clift 5:20 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Baltimore Washington Medical Center Glen Burnie Age (lo yrs. last birthday)
Yrs. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 Months Days Hours Maryland **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 1 Tes 2 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 21060 USA "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give Specify: Completed 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Installer Telephone Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ည Lena Pfeffer Harry Reese Clift 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aileen A. Clift / Wife 15 Chester Circle Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)
Cedar Hill Cemetery 10/24/2011 Brooklyn, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Signature of Funeral Service Licens Services, 1 2nd Ave.SW.Glen Burnie, Maryland21061 MC1334 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one caus, on each line. ing, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events 0 the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director. After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burlar-transit resulting in death) Last as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 DER/Outpatient 3 IDOA မ Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Chea Ceftifying Nurse-Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only

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State Registrar

29b. Signat

Richard Baum 1600 Crain Highway S.W. Ste. 41 Glen Burnie Maryland 21061 Registrar's Signatur al blooked

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0013526

29d. Date signed (Month, Day, Year)

Octobert 18, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 335!5 State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 16, 2011 Sharon Elizabeth Christenson 11:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 367 Overture Way Centreville Queen Anne's 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) **Director** 585-64-1315 1 🗆 M 2 🗶 F 59 August 28, 1952 Missouri 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Fatt if item 27 is marked other than "natural", or items 23a or 28a-f sho tant: If item 27 is marked other than "natural", or items be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Queen Anne's Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 367 Overture Way 21617 United States "natural", or items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 💢 No Specify: Specify: White 3 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Daniel Metcalf Ruth Morton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David M. Christenson/Husband 367 Overture Way, Centreville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of October 19, 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or of Montgomery Crematorium, Inc. 1 🔲 Burial 2 💢 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Bethesda, Maryland 21. Signatur of Funeral Service License Robert A. Fumphrey Funeral Home, Bethesda-Chevy Chase, Inc. Haran M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between and Death Immediate Cause (Final Phusician/ Cardiorespiratory Failure Year disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 2 Years Metastatic Renal Cancer Sequentially list conditions, Due to for as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Carcinoma of Kidney resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month Day 5 Other (specify) 1 Yes 2 2 9 Unknown 9 Unknown Part II. **Other significant ⊆onditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? General Debility 24a. Was an performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) XNatural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 and D40860 October 17, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anoma Bandara, 19241 Montgomery Village Ave., #E-23, Montgomery Village, Maryland 20886 M.D. Registrar's Signature State CARGUAN. Registrar

Please Type or Printin Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieney 0 1 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear Physician/ Alverta S. Cade october 20l Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Baltumore Hospita 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months 093-12-3232 1 □ M 2XX 90 Director June 17,1921 Maryland Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2XXNo MD Baltimore Reisterstown 10e. Street and Number 10g. Citizen of What Country? ō Patient Known As Alverta Funeral items 23a 21136 U.S.A. 306 Cantata Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. Armed Force ō þ 1 Never Married 2 Married Yes XXNo Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Hygiene. If Yes, Give Specify Black XX Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Pediatric Health Care should be filed with and Mental Hygien is marked other th Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Green Lila Baker 9a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra Ester O. Testman / Friend 811 Walton Ave. Apt. D3 Bronx, N.y. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 10-25^{ete}2011 All Faiths 1 ☐ Burial XXCremation 3 ☐ Removal from State 10/19/11 4 Donation 5 Other (Specify) Manchester, MD ory & Chapel 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of 1 Servi mo 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 days Immediate Cause (Final hemisphere bleed with hemiation Ph sician/ Left cerebral disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). nding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ atten for u in the past 12 months?
1 ☐ Yes 2 🛣 No Pregnant at time of death ed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Hyperlipidemia 24a. Was an cate has to page 2 s autopsy performed? Yes 2 No certificate or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 X Inpatient 2 - ER/Outpatient 3 - DOA မြ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural within 24 hours after death.

To the Funeral Director: After injury 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Odi RES-000 October 19 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Hospital of Baltimore Elliott Sinai MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER Day a DII OT4OAM Robert A. Davis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ST-AGNES HOSPITAL BALTIMORE 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 ☑ M 2 □ F Hours 245-42-6689 Director 80 Usual Residence of Decedent permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22. S. Athol Avenue 21229 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married unk þ If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 S. Caton Avenue Baltimore, MD St. Agnes Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🕅 Other (Specify) in state Signature of uneral Service in see Waste Wrector Bratend Africa Board 655 W. Baltimore Street Baltimore, MD 21291 23a. Pan 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final RENAL Onset and Death FAILURE Physician/ disease or condition **Medical** resulting in death) Due to (or as a consequence of) Examiner Two weeky 5 EPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) DEMENTIA UNUNDUN ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last mensun Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by AUDONS 1 Yes 2 No 3 Probably 4 Unknown EXTREMITIES GANGRENE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv performed? 2 No 1 Yes Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၀ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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Registrar DHMH 17 Rev 7/2009

State

ROBER

DAVIS

WIRENS

Registrar's Signadure

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tomma

OCT 2 1 2011

31. Date filed (Month, Day, Year)

Director

Funeral

Completed by

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Examiner

Physician/Medical

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Certificate:

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Physician/ Medical

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Funeral Director

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. State	10b. County		10c. City, Town or	Location				10d. Inside City Limits		
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FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 12 Content of pregnancy 23d. Date of display 23							elivery Day Year			
	icant conditions of	ntributing to death	but not resulting in the	e underlying cause o	iven in Part I.	23e Did tobaco	co use contribute to	o the cause of death?		
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BISSIASCE, MU PERIERSIAN DEER VERVOS, TAMEL				24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?						
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2 Accident 3 Suicide 4 Homicide	Investigation Could not be determined	28e. Place of In	jury - At home, farm, : tc. (Specify)		Yes 2 No	28f. Location (Street City or Town, St		ural Route Number,		

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the Invertal director, page 2 should be detached for use as the burial-transit ate has been signed by page 2 should be detacl

2 Accid
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4 Homid 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ir libit Henz. Howatur OCTOBER 10, 20,1 20058546

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. LIBUSE HEINZ- MO MCKONKE, 10605 CONCORD STREET #500 KENSINGTON, MID

State Registrar 31. Date filed (Month, Day, Year)

32/Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ 18 2011 8:32 PM 10 <u>Violet M. Davidson</u> Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Harford Fallston 2301 Edinburgh Drive Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year, 1 M 2 X F **Director** 216-22-9417 83 01/06/1928 Maryland Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 🗌 Yes 2 💢 No Fallston Harford MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or must be n Funeral 21047 U.S.A. 2301 Edinburgh Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. "natural", or ite Black, White, etc. Armed Forces by 1 Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify White Completed 3X Widowed 4 □ Divorced Year or Dates and Mental Hygiene.
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aumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Social Security Admin. Social Security Supervisor 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or other 2 Treva Richarts Jacob Garrett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Ridgecliff Court - Kingsville, Maryland (son) Frank G. Davidson, Jr. Viole+ 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air, Maryland Bel Air Memorial Gdns 10/24/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland ac 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Colon Onset and Death Cancer. Immediate Cause (Final disease or condition ta Physician/ Medical resulting in death) consequence of Examiner Sequentially list conditions, it is a diate cause. Enter Underlying Examine Due to lor as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the use as f attending IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No Pregnant at time of death Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 s has 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate 2 To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, many opinion, detail occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day Year) 29b. Signature and certifie 510 Upper Chesapeake Dr 30. Name and add ress of person who Air, MD 21014 31. Date file 32. Registrar State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-07733 State of Maryland / Department of Health and Mental Hygiene Ott Howard Davis, Jr. Certificate of Death - For State Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 3. Time of Death 2. Date of Death Physician/ Da Month 1112 hrs Davis Jr. Howard October 15, 2011 Ott **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Annapolis 2900 Shipmaster Way #214 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Months Country) 31 NY Director 05 22 057-24-1040 1X M 2 F 80 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 X No Annapolis Anne Arundel MD notified at once, permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21401 2900 Shipmasters Way Apt 214 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral White, etc. White 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes Specify: Black 1 Yes 2 X No specify: If Yes, Give Year 3 X Widowed Š 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Architect Engineering Elementary/Secondary (0-12) College (1-4 or 5+) Specialty Company Architect Baltimore, MD 21215-0036 2yrs 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Smith Ott H. Davis Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဂ္ 1200 Conkling Street, Baltimore, Md 21224 O. Davis Richard 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10/26/2011 Delaware, Sandy Ridge Church Donation 5 Other Specify unature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West mul 21215 4300 Wabash Ave, Baltimore, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and aiture. List only one cause on each line Death /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and - transit law requires that the death certificate be executed hysician/Medical X AMENDED #14perFH, G921, 11/1/2011, WS UNPENDED ned by the attending physician a detached for use as the burial -Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IE EEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by ti P.O. 굽 1 Yes 2 No 3 Probably 4 Unknown Ś Diabetes mellitus Completed 24b. Were autopsy findings available 24a. Was an Reportes, een prior to completion of cause of autopsy performed? death? has 2 No Yes 2 V No 1 Yes The pag certificate 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medica of Vital Be Hospital: 1 examiner? Other Nursing Home 5 Residence 6 Other: Scene DOA Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes ٩ 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: thin 24 hours after death.

o the Funeral Director: A 1 V Natural 1 Yes 2 No Division Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 3 Suicide Could not be determined (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Sal To the one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 16, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner Zabiullah Ali, M.D.

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year

2 1 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Ferdinand Eberhart, Jr. 2:00 P M October 0 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 311 Tuscany Road Baltimore Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours Min 220-36-2368 Director 1**X** M 2 □ F 12/6/1938 Maryland 72 or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore Maryland 10e. Street and Number items 23a or ner must be n 10f. Zip Code 10g. Citizen of What Country? 0 Funeral 311 Tuscany Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 College (1-4 or 5+) Elementary/Secondary (0-12) Developer Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Ferdinand Eberhart, Sr. Evelyn Muth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21210 Linda Jarvis Eberhart / Wife 311 Tuscany Road 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 10/22/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) orraine Park Cem. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Memstanic prostate cuncer

Due to (or as a consequence of): Onset and Death Immediate Cause (Final Physician/ 12/7/2010-10/18/20 disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Physician/Medical Examiner Due to (c) as a consequence on if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the buris IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Box 1 ☐ Live Birth 2 ☐ Ferancea 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?
1 Yes 2 No Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after ovecu... • Funeral Director: After this certificate ovec a letely filled in by the funeral director, page 2 s autopsy performed Yes 2 2 🗌 No Yes Hospital or Attending Physician: 25. Was case referred to medical Division of Vital To Be 26. Place of Death (Check only one) 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 28 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated npletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the F

complet Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Green Spring Stoken, PAVILLAIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Victoria Sinibald CANP, Green of

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

10/18/2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October John A. Engers, Jr. 2011 2:32 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Phoenix 8 Fairwood View Court 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 217-20-7590 **Director** 1 X M 2 F 84 Nov. 3, 1926 Maryland 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 X No MD. Baltimore Phoenix 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8 Fairwood View Court 21131 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black White, etc. b 1 Never Married 2 X Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 5+ the Medical Doctor Medicine event, Be Department of Health and Namel Hills Inportant: If item 27 is marked oth any injury or other traumatic conce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Catherine Rhein John A. Engers, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor P. Engers/ Wife 8 Fairwood View Ct. Phoenix, MD. 21131 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Spenitombment oudon Park Cemetery 10-24-11 Baltimore, MD 21. Signatur of Funer Service 22. Name and ARTUCK FTOWSON Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Six mon Immediate Cause (Final Physician ancer hng disease or condition Medical resulting in death) Due to (or So consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): use as the burial-tran attending physician and Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No **Division of Vital** funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1X Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title dries M.D. Well U. Anime, M. D. D. 17873 October 20, 2011

vpo completed cause of death (Item 23a) (Type, Print)

Levine 6569 Worth Charles Street Towson, Maryland 2120

Registrar

State

32. Registra 's Signature

person who completed Call

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#10e,19b, perFH, G920,10/25/2011, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) Margaret 2. Date of Death Grace Graham Day 4:30 PM Physician/ 201 Medical 4a. Facility Name (if not institution, give street and number)
Montgomery General Hospital 4b. City, Town, or Location of Death 4c. County Montgomery **Examiner** 9. Birthplace (State or Foreign Country) M A If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number 022-09-1384 **Funeral** 04747 By 1991 7 Min. Days Hours MA 1 M 2X F 94 Director Yrs 10d. Inside City Limits show 10a. StateMD 10b County Montgomery 10c. City, Town or Location Silver Spring notified at Director 1 X Yes 2 No 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number I Hygiene. I other than "natural", or items 23a or vent, the Medical Examiner must be r 20906 Glade Drive, Apt. 2A Funeral with t Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death (14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give ģ Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examiury or other traumatic event, the Medical Examius Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🙀 No Specify: Specify: Completed 3 X Widowed 4 □ Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname)
Miriam Creighton 17. Father's Name (First, Middle, Last) Delahanty မ Joseph William apt Mailing Address (Street and Number or Bural Rost a Number Fit Fit & For Spirit Rige and Drive, Apt. 2A, "Si fit & For Spirit Rige" 19a. Informant's Name/Relationship (Type, Print)
Ann Alicia Graham/Daughter 15111 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Department of I Important: If its any injury or of once. 10/22/2011 At l'anti c'emetery or ester place Glen Burnie, MD 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility semation Servi MBS 21203 21. Signature of Funeral Service Licensee Dorota Marshall lua 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Preumonia disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? s certificate has b director, page 2 s autopsy performed? Yes 1 TYes 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ER/Outpatient 3 DOA 2 No this 28b. Time of 28d. Describe how injury occurred 28a. Date of injury 28c. Injury at 27, Manner of Death 1 Natural within 24 hours after death.

To the Funeral Director: After t completely filled in by the funer. (Month, Day, Year) injury work? 5 ☐ Pending _ Investigation 1 \(\text{Yes} 2 🗌 No Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 3 🗌 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October 54996 2011 Linh Dichhum 30. Name and address of derson who completed cause of death (Item 23a) (Type, Print) 20832 Drive, Olney Prince Bichhuan 18101 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33525 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Godbolt Diane Martha 3:05p. Medical 10 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 1141 Ellicott Drive Way If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year) Country) Director 213-46-4921 1 □ M 2 😿 F 66 MD Yrs 45 06 17 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene.

I is marked other than "natural", or items 23a or 28a-f shorraumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director NA Baltimore 1 XYes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21216 U.S.A. 1141 Ellicott Drive Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes No If Yes, Give Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Save Rite life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Lottery Operator 2th grade na Supermarket Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ewonce. ည Ophelia Boddie William Waddy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 1141 Ellicott Drive Way, Baltimore, Md George Godbolt-Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) 10/17/2011 Baltimore, Md On-Site gna ure of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Av Baltimore, Md Ave Fart 1. Enter the disease, or complications that caused shock, or healt failure. List only one cause on each line used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nterval Between et and Deat Immediate Cause (Final Physician/ GECTAL ANCER disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examin Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ____ signed by the atte in the past 12 months? Month Dav Pregnant at time of death 1 Yes 2 No Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 7 To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify) 4 Nursing Home 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural (Month, Day, Year) 5 Pending death. Accident 1 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c. License number

Registrar

DHMH 17 Rev 06-2011

State

KAREN

31. Date filed (Month, Day,

SMITH

2835

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HEILUITT MI)

DO043375

21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Frank A. Grecco, Sr. 2250 PM 2011 Medical 10 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN Square HOSPITO Rosedale Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F 219-12-5016 Hours Min. 86 OT/03/1925 CoMaryland **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD n/a Baltimore 1 XXX 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1004 Dalton Ave. 21224 USA death 1 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner o. Black, White, etc. þ 1 Never Married 2 Married ^{2 □} NNavy Yes, Give Baltimore, Maryland 21215-0036 72 hours after permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", any injury or other traumatic event, the Medical Francoice. 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Police Office Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oreste Grecco Theresa Rossi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra A. Netro (Daughter) 7659 Simpson Road, Glen Rock, PA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🌠 Burial 2 □ Cremation 3 □ Removal from State 4 □ Dongtion 5 □ Other (Specify) cemetery, crematory or other place) Parkwood Cemetery 10/21/11 Baltimore, Maryland 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 21. Signatu of Funeral Service License 6224 Eastern Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Interstitial disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Directors After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled. Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? Day Year 4 Pregnant at time of death 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cardiomyopathy Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 100 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☑ No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate; To 1 ☑ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending iniury Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier D72764 10-17-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

DR Devadatta

31. Date filed (Month, Day, Year)

A Sarwate

32. Redistrar's Signature

Frank

parket

9000 FRANKLIN SQUARE DR Balto md 21237

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death october ¹³8,20°11 Physician/ 10:58A M Alice Mary Gjerde Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL TOWSON CENTER BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🕮 F Hours 484-46-0712 (Month, Day, Year) 11/22/1939 **Director** 71 Iowa Usual Residence of Decedent 28a-f show 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Maryland Baltimore Cockeysville 1 Tes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a 8 Clipping Tree Lane U.S.A. 21030 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🗓 No If Yes, Give ģ 1 Never Married 2 K Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked or traumatic eve ပ္ Charles Silletto Ada Not Known 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David W. Gjerde / Husband 27 8 Clipping Tree Lane Cockeysville, Maryland 21030 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Date 10/21/2011 Towson, Marvland 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ SEPSIS disease or condition resulting in death) Medical e to (or as a consequence of): CLOSTRIDIUM DIFFICILE COLITIS **Examiner** Securitially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical P.O. Box 68760 as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 1 ☐ Yes 2€ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?
☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: ည 1 🗌 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) e Hospital or Attending P 24 hours after death. e Funeral Director: After t 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 1 🗌 Yes 2 🗌 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed Month, Day, Year) D24034 of death (Item 23a) (Type, Print) 30. Name and address of person who completed TIMOTHY LOW, M.D. OSLER DRIVE TOWSON, MD 21204 7601 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12:01 A M Physician/ Mazie Henson OCTOBER Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Randallstown Latimore Northwest Seasons Hospice Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 216.20.9608 Hours Min. MD 1 □ M 2 🔀 F **Director** 31 D Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f shorexaminer must be notified at Director Baltimore 1 Yes 2 No Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral Koag death with 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 1. Marital Status Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 No permit. Page 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examionce. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Social Securita College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie Brooks မ Hookins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore MD 6922 (Daughter Darlene Kaaa 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Woodlawn, MD 10/27 2011 1 Burial 2 Cremation 3 Removal from State Woodlawn Conneteru 4 ☐ Donation 5 ☐ Other (Specify) ughn C. Greene Funera Iservices Randal)storn MD 21133 22. Name and Address of Facility Vaugnn 21. Signature of Funeral Service Licensee Kbad 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death Atheroscherotic Cardiovascular Disease Immediate Onuse (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed -tran Due to (or as a consequence of) physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) g Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 Yes 2 No ours after death.

eral Director: After this certificate I filled in by the funeral director, pag Yes 2 ✓ No 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be 4 Nursing Home 5 Residence 6 Other (Specify) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 2 🗹 No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at 1 Natural injury 5 Pending 1 Yes 2 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/20/11 USKY spalmeMiD D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 2 1209 5 203 S Rajopakse, MiD 2835 Smith Date filed (Month, Day, Year)
OCT 2 1 2011 32. Registrar's Signature State

Registrar

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State of Maryland / Department of Health and Mental Hygiene () 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month 9:45 PM 2011 **Physician** HERGE OCTOBER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore 321 Magnolia Terrace Essex 8. Date of Birth June 18, 1920 9. Birthplace (State or Foreign If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Min. Maryland Hours Months **Funeral** 1 □ M 25 F 91 Yrs. 220-05-3899 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County item 27 is marked other then "naturel", or items 23e or 28a-f show other treumatic event. Its Nedical Examiner must be notified at 1 Tyes 2 XXX Essex Directo MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code Pages 1 and 2 should be filed within 72 hours after death with USA 21221 321 Magnolia Terrace Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣ No Black, White, etc. White 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 3 XXidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental P Robinson Catherine Joseph J. Herold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6800 Bank Street, Baltimore, MD Catherine Simon (Daughter) item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition of 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland = 5 permit. Page Department o Importent: If eny injury or once. Baltimore Natl. Cem. 10/21/11 5 Other (Specify) 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. of Funeral S. rvice Licens 21 Signaturi 6224 Eastern Ave., Baltimore, Maryland 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YEARS Pnysician DEMENTIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the t IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2√2No Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 2 **□**₹No 1 ☐ Yes ARTERY DISEASE, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an FIBRILLY ATRIAL autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital or Attending Physicien: 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Lo 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number City or Town, State) Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D62032 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 5505 JENNIFER HAYASHI HOPKINS BAYVIEW CIRCLE BALTO, MD 21224 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) OCTOBER ^D 20° 1 1 Physician/ 4:35 P M Charlotte Burns Hosier Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTER 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Country)
Maryland Months Hours 1 □ M 2 🕱 F 218-22-5488 4/11/1926 Director Usual Residence of Decedent or 28a-f show notified at 10d Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 X No Maryland Baltimore Lutherville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö ed other than "natural", or items 23a or event, the Medical Examiner must be Unit 102 21093 Funeral 10 Stapleton Court U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 No þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ¥ No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fi Department of Health and Mentai Important: If item 27 is marked any injury or other traumatic ev မ Margaret Reiner John P. Burns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 19a. Informant's Name/Relationship (Type, Print) 10 Stapleton Court Unit 102 Lutherville, MD Robert L. Hosier, Jr. /Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State Hilltop Serv. Corp. 10/21/2011 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 11050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Colitis Difficile Provincian/ 5 days Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the serving Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the atternormpleted filled in by the funeral director, page 2 should be detached for in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🗗 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DDA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

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State Registrar

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29a. Certifier

only one)

29b. Signature and title of certifie

Collan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles

DHMH 17 Rev 7/2009

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

00043489

Year

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201₁ 6:40 p. M October 18, Barbara Hall Ann Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Prince Georges 4142 Bunker Hill Rd. Brentwood Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours (Month, Day, 246-64-0328 69 Director 1 🗆 M 2 🛣 F May 2, 1942 North Carolina Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10c. City. Town or Location Director notified 28a-f 1 Yes 2 X No MD Prince Georges Brentwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ms 23a or must be n Funeral United States 20722 4142 Bunker Hill Rd. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner mus once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Black 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Child Care Provider Day Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Bertha Hall Will Artis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Linda A. Wells 2640 Enterprise Pl. Waldorf, Maryland 20601 (daughter) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Oct. Date 22, 20c. Location - City or Town, State cemetery, crematory or other place)
Chesapeake Crematory 2011 Beltsville, MD. 4 ☐ Donation 5 ☐ Other (Specify) signature of Funeral Service I 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Ave. Silver Spring, Maryland 20910 M00982 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
years Immediate Cause (Final Ph_sician/ Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has funeral director, page 2 After this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 \(\to \) Nursing Home 5 \(\text{X} \) Residence 6 \(\to \) Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 2 No within 24 hours at er death. To the Funeral Director A 2 Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide determined filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 3 🗆 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number October 19, 2011 D41715 Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 HANDOVER DR. #301 HELRA GREENbelt IND VENKATRAMAN. 32. Régistrar's Signature 31. Date filed (Month State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month SOFL Jones 62:58 AM Shirley Levi Medical 4b. City, Town, or Location of Death
Baltimore 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Sinai Hospital 8. Date of Birth 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Davs Hours Min. 27 231-28-7699 Director 1 😿 M 2 🗆 F 01 32 VΑ 79 Yrs Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Director Baltimore NA MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral U.S.A. items 23a 21216 4825 Beaufort Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian. Medical Examiner Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2 No If Yes, Give Year or Dates. "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced Black Completed Johnes 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. life DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) Lumber Company Truck Driver event, the 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Lee Williams Burkley Jones that Known as Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4825 Beaufort Ave, Baltimore, Md 21215 Sharon Samuel-Grandaughter 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Owings Mills, 10/26/2011 Garrison Forest Funeral Service License ouce. 21. Sign March F/H West τ 21215 4300 Wabash Ave, Baltimore, 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical certificate be P.O. Box 68760 the use as IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an page 2 autopsy performed? Yes 2000 has Hospital or Attending Physician: The 24 hours after death.
 Funeral Director: After this certificate I 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 80 No 1 Yes ည 1 Inpatient 2 FR/Outpatient 3 IDOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury Natural 2 Accident
3 Suicide work?
1 Yes 2 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Centifying Nurse Fractitioner: To the best of my world by coally accurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HMAN Tammand

Registrar

DHMH 17 Rev 06-2011

State

Date filed (Month

ay, Year)

Registrar's Signature

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Jones Year Zoll Margaret 250 M OCTOBER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE MIDDLE RIVER WOODLANDS ASSISTED LIVING If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) ocial Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 215-18-9072 1 🗆 M 2 🔀 F **Director** 89 10/7/1922 MD 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified BALTIMORE 1 🏋 Yes 2 □ No MD N/A 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be r Funeral USA 21206 3807 WHITE AVE ral", or item Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes No If Yes, Give Year or Dates. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygener. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 □ Divorced Specify: WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. d other than " event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) FEDERAL GOVERNMENT CLAIMS EXAMINER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WALTER PINKOWSKI MYRTLE HART 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $106\ BREAKWATER\ CT\ JOPPA$, MD 2108519a. Informant's Name/Relationship (Type, Print) 106 BREAKWATER CT GARY JONES-SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State cemetery, crematory or other place) 10/20/11 BALTIMORE, MD PARKWOOD CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 21. Signature of Funeral Service Licenses B BALTIMORE, MD 21206 6415 BELAIR RD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final LUNG Onset and Death cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been simpled. burial-transi Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death signed by the at Id be detached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed Yes 2 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other Specify NO Facility ဂ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manger of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred ✓ Natural 5 Pending Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Myapalnin D 20057465 10/17/11

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N = 5 · Rajapa KSI / M · D · 2835 5m · M · N

32 Registrar's Signatu

31. Date filed (Month, Day, Year)

5203 Bylhimore MD 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2

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			For State Registrar	State of Marylar		rtificate of E			Reg. No.		
Physician/			Decedent's Name (First, Middle, Last)	2. Date of			th Day Year	3. Time of Death			
Medical		cal	4a. Facility Name (if not institution, give si	4b. City, Town, or Location of Death			4c. County of Dea				
Examiner			2247 Sidney Avenue	Baltimore N/A							
	Funeral Director		5. Social Security Number 141-32-5017 Usual Residence of Decedent	7. Age (In yrs. I	ast birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 02/08/1	y Year) g. Bi C. L934 Hung	rthplace (State or Foreign ountry) gary	
	Maryland 8a-f show tified at	To Be Completed by Funeral Director	10a. State 10b. County N/A		ty, Town or Lo					10d. Inside City Limits 1 X Yes 2 No	
9200	n with the is 23a or 3		10e. Street and Number 2259 Sidney Avenu	ıe		10f. Zip Code 21230)		10g. Citizen of What C	ountry?	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates.		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🏋 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.	
21215-0036	ithin 72 hor ene. r than "nat		15. Decedent's Edu · (Specify only highest gradential Secondary (0-12) 12	de completed)		. Decedent's Usual Occupation (Give kind of work done during most of worki life. DO NOT use retired) gineer		king 16b. Kind of Bu Westing		siness/Industry house	
Maryland 2	d be filed w Aental Hygi irked other		17. Father's Name (First, Middle, Last) Unknown				18. Mother's Nam Unknow		Maiden Surname)		
Baltimore, Mary	nd 2 should ealth and N m 27 is ma ier trauma		19a. Informant's Name/Relationship (Typ Roy Whaley Frie	end	2247	Si d ney Av			r, City or Town, State, Z MD 21230	tip Code)	
	. Page 1 a treet of H trant: If ite jury or oth		20a. Method of Disposition 1		dent C	osition (Name of matory or other place remation	10/2		Hanover, N	MarylaND	
Ball	permit Depar Impor any in		21. Signature of Funeral Service Licenser	illo-	6	2. Name and Addres 009 Harfo	ord Road	rzullo E Baltimor	Funeral Cha ce, MD 2121	pel,P.A.	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition							Approximate Interval Between Onset and Death				
Medical resulting in death) Examiner Due to (or as a consequence of):											
	uted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that Initiated events	uence of):							
0	cate be executed physician and s the burial-transit		resulting in death) Last	uence of):							
68760	rtificate ling phy e as th	/Med	IF FEMALE:	3c. If yes, outcome of pregnancy							
. Box (ne death certif / the attending ched for use a	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	al death 3	Country Countr	ey		23d. Date of delivery Month Day			
ls, P.O.	uires that the dea in signed by the a uld be detached f		Part II. Other significant conditions cor	atributing to death but not res	ot resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 ☑ No 3 □ Probably 4 □ Unknown		
Division of Vital Records,	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Completed by							prior to rmed death?	utopsy findings available completion of cause of es 2 \(\square\) No	
ital	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	1	Oth	ace of Death (Chec		- Frien	a's home	
n of V	nding Phys tth. thatter this e funeral di	Medical Certificate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 28c. Injury at work?							
Divisio	al or Attend s after death al Director; al ed in by the		3 Suicide 6 Could not be 4 Homicide determined	t be 28a Place of Injury - At home farm street factory office 28f Location (Street and Number of					ural Route Number,		
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b		(Check 2 Medical Examin	cian: To the best of my know er: On the basis of examination Practitioner: To the best of	on and/or inves	stigation, in my opinio	on, death occurred a	at the time, date a	ind place, and due to the	e cause(s) and manner stated.	
MS Key isparticion 00057-465 10								10/18/	ate signed (Month, Day, Year)		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N-5. Rajn Pakse, MID: 28355 min AV \$ 203 Baltimore MD 21209.								209.		
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 1 2011	32. Registrar's Singa	this for						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 ber Alberta Kuys Year 10 204 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City. Town, or Location of Death Baltimore Randallstown Season's Hospice 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Months Hours Min Director 218-36-5710 MD item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD NA Baltimore 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21215 U.S.A. 3805 Cottage Ave 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married ģ 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Black Specify. Completed 3 Widowed 4X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private Duty Nursing Coney Agency <u>12th grade</u> Be Department of Health and Mental Hy Important: If item 27 is marked other any injury or other transment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Albert Johnson Daisy Bradley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3805 Cottage Ave, Baltimore, Md 21215 Anita Marine-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 10/22/2011 Memorial Park Woodlawn, Md 21. Si of Funeral Service License 22. Name and Address of Facility
March F/H West
4300 Wabash Ave. Baltimore. 23a. Par 1. Enter the drease, or complications that costs of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirtk, or heart filter. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Kewal Physician/ End-Stale Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ned by the are detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛂 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ms Ky apaknem. D 20057465 10/17/11

38

Registrar
DHMH 17 Rev 7/2009

SMITH AV

5203 Baltimore MD 21209.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N S. Rajapakse, M.O.

31. Date filed (Month, Day, Year)

2835

32 Registrar's Signature

Please Type or Printin Black-Indelible Ink Engure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death M10/18/2011 Physician/ Louise Paulson Kupelian 6:53 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chevy Chase Montgomery 4806 Falstone Ave. If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours 194-18-7111 1 🗆 M 2 🔭 89 **Director** 01/09/1922 PAUsual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director Chevy Chase MD Montgomery 1 Yes 2 KNO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a 4806 Falstone Ave. 20815 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Examiner Armed Forces Black, White, etc. or. 1 Never Married 2 ☐ Married by 1 Yes _ If Yes, Give Year or Dates Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ♠ No Specify. Specify: White 3 Widowed 4 Divorced ed other than "natural", event, the Medical Exa Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 h and Mental Hygiene. 7 is marked other than "' College (1-4 or 5+) Elementary/Secondary (0-12) Pianist / Music Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leondiades permit. Page 1 and 2 should be Department of Health and Ment. Important; If item 27 is marked any injury or com. Michael Paulson Anastasia Paul 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4631 Chestnut St., Bethesda, MD Diane L. Kupelian / Daughter 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 10/21/2011 Beltsville, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Multiple Cerebrovascular Accident's Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Cerebrovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Hypertension Due to (or as a consequence of) nding physician Physician/Medical certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Hospital or Attending Physician: The law requires that the death Month Day Year Pregnant at time of death 5 Other (specify) ☐ Pregnam.
☐ Unknown signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy performed? 1 Yes 2 V No 1 Yes 2 No this certificate funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) (0) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes 2XXNo 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After injury XX Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD-6165 October 20, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3301 New Mexico Ave. NW, #342, Washington D.C. 20016 Mary Restifo, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 17, 2011 **Physician** 12:50 P M October Rajeshwar Kishore /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Silver Spring
If Under 1 Year | If Under 24 Hrs. | 8 Arcola Health & Rehabilitation 9. Birthplace (State or Foreign Country)
India 8. Date of Birth (Month, Day, Year) January 2, 1918 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1 X M 2 □ F 93 385-84-4327 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if frem 27 is marked other than "natural", or items 23a or 200.000.000. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2X No Funeral Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20904 13100 Riviera Terrace 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐Yes 2 X If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify: Completed by 3 Widowed 4 Divorced Indian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Indira Kishore Jaigopal Kishore ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13100 Riviera Terrace, Silver Spring, Maryland 20904 Anil Kishore / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of Cometery, crematory or other place) Date 20a. Method of Disposition October 20, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2011 Bethesda, Maryland Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home/Bethesda-Chevy Chase, Inc. John the 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Hypertension Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Kidne. Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an autopsy performed 1 □Yes 2 □No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 → 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 24 hours a the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only and manner stated. within 2. 29c. License number
00064624 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (inelly)

Registrar
DHMH 17 Rev 1/2001

leted cause of death (Item 23a) (Type, Print)
743 SUMMEN WALK DR. GAZTHENSBURG, MD 20878

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANDEEF SHARMA
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G920, 10/21/2011, WS
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month 0 Day 0655 AM Kilgore 20 Medical 4a. Facility Name (if not institution, give eet and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Word 8. Date of Birth (Month, Day, Year) 7. Age (În yrs. last birthday) If Unde 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Hours Min. Country) Director VOV. 35 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location with the Maryland Director 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 30 within 72 hours after death 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 \(\text{No} \) No Army

If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, <u>the Me</u> Elementary/Seconday (0-12) College (1-4 or 5+) 8 onStru Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a. Informant's Name/Relationship (Type, Print) or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date DIK cemetery, crematory or 21. Signatur Fur ral Servic License any inj once. . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death sbock, or heart failure. List only one cause on each line. Stroke Immediate Cause (Final Physician/ disease or condition resulting in death) day Medical Due to (or as a consequence of): Examiner 1 theosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated exects.) Completed by Physician/Medical Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death
Unknown 5 Other (specify) ια une runeral unrector. Atter this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached i 1 L Yes 2 L 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an After this certificate has autopsy performed Yes 2 25. Was case referred to medical Sion of Vital Be 26. Place of Death (Check only one) examiner? Hospital: ပ 1 🗌 Yes 2 4 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: Hospital or Attending injury 1 Natural 5 Pending 2 Accident
3 Suicide Investigation n 24 hours after deat e Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗲 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my spinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signatur 29d. Date signed (Month, Day, Year) 29c. License number D0063964 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Healman Giller 9733 oje 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 20 33539 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Robert Aaron Kilduff Sr. /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner rankin Saua timore asedale If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1**⊠**M 2□ F June 6, Yrs. 1942 215-40-0536 69 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Maryland Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA or Items 23a 1821 Steven Drive 21040 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Specify ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Mental Hygiene, larked other than Elementary/Secondary (0-12) 12 College (1-4or 5+) State Trooper State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland permit. Pages 1 and 2 should be. Department of Health and Mental important: if Item 27 is marked oth any Injury or other traument once. Be ပ Albert Richard Kilduff Sr. Ruby Marie Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 900-B Tydings Lane, Havre de Grace, Maryland Cheryl Kilduff / Daughter 20a. Method of Disposition
1 ☐ Bufial 2 ☑ demationy 3 ☐ R
4 ☐ Donation 5 ☐ Other (Specify) Date 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 3 Removal from State Hilltop Service Corp. 10/19/2011 Towson, Maryland 21. Signature of Fun 22. Name and Address of Facility McComas Funeral Home, P.A. ice Licensee U 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** udomonas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last s a consequence of): Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 🗹 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was ...
autopsy
performed?

Ves 2 No certificate 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of P Hospital or Attending P 24 hours after death. Funeral Director: After t 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/17/2011 anver, Mo. PhD 00070158 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Balto. Mb 21237 nKIM Square 31. Date filed 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Σ	:	1	For State Registrar	State of M	arylan		artmen tificate			and Me	ental Hy	giene Reg. No2	011	335	540
	Physicia	n/	Decedent's Name (First, Middle, Last,)							2. Date of De		19,ŽÕ1	3. Time o	f Death
-	Medic Examin	_	Mary Ann Kenning 4a. Facility Name (if not institution, give s	street and number)			4b. City,	Town, or	Location o				ounty of Deat		lood F IVI
-	,		Saint Joseph 5. Social Security Number 6. Security Number 16.				If Under	1 Year	If Under 2	0W S 0 T	8. Date of Bir			hplace (State	or Foreign
	Funeral Director		213-26-7204		32 32	st birthday) Yrs.	Months	Days	Hours		eb. 2,	^y 1929			yland
	and Show Lat	II. I	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside C	City Limits
	Maryla 28a-f	irect	MD Baltimore	<u> </u>	Tow	son									s 2 No
	with the 23a or ist be r	eral	10e. Street and Number 204 E. Joppa Road	Apt. 904	4		10f. Zip					10g. Citize	n of What Co	untry?	
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 4 If Yes, Give Year or Dates.	Ever in U.S		Was Deceder f Yes, special			gin? (Spec , Puerto R	ify Yes or No- lican, etc.)		. Race - Ame Black, White pecify: W		
21215-0036	rithin 72 hou lene. r than "nat i the Medica	Complet	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12) 12		5+)	16a. Deced (Give i life. De Secre	kind of wor O NOT use	k done di	ition uring most	of workin	g		of Business n Offi		
Maryland 2	ld be filed w Mental Hygi arked othe atic event,	ادما	17. Father's Name (First, Middle, Last) William E. Madden						18. Mothe		(First, Middle nning				
Mar	2 shouth and the and t		19a. Informant's Name/Relationship (Ty) Donald Madden	oe, Print) / brothe:	r						Route Numbe Baltimo				
nore,	age 1 and int of Hea t: If item / or other		20a. Method of Disposition 1 Burial 2 Decemation 3	Removal from State	20b. P	lace of Dispo	sition (Nam natory or ot	ne of ther place	e)	Da	ate	20c. Loca	ation - City or	Town, State	
Baltimore,	permit. Pa Departme Importan any injury once.	100	4 Donation 5 Other (Specify 21. Signature of Fu	Que	рша	22	2. Name and	d Addres	s of Facility	у	/2011 Home,		1050	York R on, MD	
C	Pnysician) Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each lin RESF a. Due to (or as	e. PIRAT	ORY F			g, such as (cardiac or	respiratory a	rrest,		Approxima Interval Be Onset and	etween
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or an	e dunskiqii	innoi ufi									
hg.	te be executed nysician and ne burial-transit	ical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as		EFFUS	BION								
68760	ificate big physical as the b	Medic	IF FEMALE:	d											
. Box 6	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 N No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 🔲 Feta at time of c	al death 3	Ectopic p		у			23	d. Date of de Month	live ry Day	Year
ls, P.O.	uires that t in signed b uld be deta	ed by P	Part II. Other significant conditions co			ulting in the ι	underlying o	cause giv	en in Part I	I.				o the cause of Probably 4	
Division of Vital Records,	The law rec ate has bee page 2 sho	Complet									per	s an opsy formed? 2 X No	prior to death?	topsy findings completion of s 2 🗆 No	s available cause of
/ital	sician: certific irector,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🄀 No	Hospital:	* 0 □	ER/Outpatie	-	T _{O+b} .	ace of Dear		only one)	:d-=== 6 [Other (See	-(6.)	
n of \	nding Phy nth. : After this funeral d	cate: T	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of inj (Month, Da	ury	28b. Time of injury		8c. Injury work	/ at	2	28d. Describe			<u>y)</u>	
Divisio	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	jury - At ho tc. (Specify		eet, factory	, office		2		(Street and I wn, State)	Number or Ru	iral Route Nun	nber,
_	Hospital 24 hours Funeral eted filled	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Examin only one) 3 Certifying Nurs	ner: On the basis of	examination	n and/or inves	tigation, in	my opinic	on, death or	ccurred at	the time, date	and place, a	nd due to the	cause(s) and n	nanner stated
	To the within 2 To the comple	Σ	only one) 3 \square Certifying Nurs 29b. Signature and title of certifier	Practioner: 10 til					number	e and place	e, and due to	29d. Date	signed (Mon	h, Day, Year)	
	\cap		Ile o	Lh		10	D.:-A	DC	00678	248		Oco	tobe	V20	,2011
	Sa		30. Name and address of person who c GRETCHEN _DICK			7601		R D	RIVE	то	WSON,	MARY	LAND	21204	
	Sta Registr		31. Date filed (Month, Day Year)	32. Regist	rar's Signa	back	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

		-	For State Registrar	otato or maryian		ificate of E	Death	F	Reg. No. 0	33541
			1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	Day Yea	3. Time of Death
	Physicia /Medic			Lokosinski		4h Cihi Taum or	Location of Death	october	- 19 201 4c. County of De	
3	Examin	er	4a. Facility Name (If not institution, give			Baltimore	Location of Death		40. Godiny of Bo	
			Johns Hopkins Bayvie 5. Social Security Number 6. S	ex 7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h 9. E	Birthplace (State or Foreign Country)
	Funeral Director		224-40-2915	□м Ж□г 78	Yrs.	Months Days	Hours Min.	SEPT6	,1933 V	IRGINIA
	pu 3		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Loc	cation				10d. Inside City Limits
	f sho	ō	MD.			RE CITY				1 X Yes 2 □ No
	r 28a- notifie	Director	10e. Street and Number			10f. Zip-Code			10g. Citizen of What 0	Country?
	th with		703 SOUTH ELL	WOOD AVENUE		212			U.S	
	tems er mu	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 € No If Yes Give	S. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wl	nerican Indian, hite, etc.
30	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23a or 28a-f show attle event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specify: W	HITE
3-00-c	2 hou atural cal Es		15. Decedent's E		16a. Deced	ient's Usual Occup	ation during most of work	dina .	16b. Kind of Busine	ss/Industry
<u> </u>	thin 7 e. an "n Medi	Completed	(Specify only highest grant [Secondary (0-12)]	College (1-4 or 5+)	life. L	OO NOT use retired E MAKER	0	9	OWN HO	ME
V	led wi lygien her th nt, the	Co	17. Father's Name (First, Middle, Last)		11011		18. Mother's Nam	ne (First, Middle	, Maiden Surname)	
200	hould be filed withir id Mental Hygiene. marked other than mattc event, the Me	Be c		AY			MAUDE	STROOP		
-	d 2 should th and Men 7 Is marke traumatic	욘	19a. Informant's Name/Relationship (and Number or Ru	ral Route Numb	per, City or Town, State	
Ma	s 1 and 2 should of Health and Mer Item 27 Is mark other traumatic		GABRIEL KOKOSI					AVENUE		RE, MD21224
more,	Pages 1 annent of He		20a. Method of Disposition 14 Burial 2 Cremation 3			sition (Name of matory or other plac		OBER	20c. Location - City	
Ĕ	t. Pag tment tant:		4 Donation 5 Other (Special	(y) SA	CRED	HRT OF	JESUS 2	2,2011	BALTIMOR	E, MARYLAND
galt	permit. Pages Department of Important: If II any Injury or once.		21. Signature of Funeral Service Licer	MUC						AL HOME, PA , MD. 21222
			23a. Part 1. Enter the disease, or com	plications that caused the deat						Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition							Onset and Death
	/Medical		resulting in death)	Due to (or as a consec		,				
	Examiner	Į.	Sequentially list conditions, if any, leading to immediate	b. Fschenic Due to (or as a consec		ofic so	اعدا			ldey
	ed nsit	Examiner	Cause (Disease or injury	Due to (or as a consec	querice oi).					
	execut n and ial-tra		that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
98/90	tificate be executed g physician and as the burial-transit	Medical		d						
_		/Mec	IF FEMALE:	23c. If yes, outcome of pregr	ancy				00d Data of	dolivon
o n	v requires that the death cert been signed by the attending should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 menths?	1 Live birth 2 Fet	al death 3	☐ Ectopic pregnand ☐ Other (specity) _	су		23d. Date of Month	Day Year
л О	the de	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown						
	requires that the een signed by the	by P	Part II. Other significant conditions	contributing to death but not re	sulting in the	underlying cause g	iven in Part I.	i		te to the cause of death? Probably 4 1 Unknown
ğ	equire en sig ould b									e autopsy findings available
Š	≥ ~ ~	Completed						24a. Was auto perf	opsy prio formed? deal	r to completion of cause of
<u></u>			25. Was case referred to medical				26. Place of Dea	1 ☐ Yes		Yes 2 No
5	Physician: Tr this certificate ral director, pa	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oti	nor		sidence 6 🗌 Other (Specify)
0	Ilng Physician: T. After this certifications funeral director,		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju	ry at	28d. Describe	how injury occurred	
SIO		catic	2 Accident investigation 3 Suicide 6 Could not		omo form et		Yes 2 No	28f Location	(Street and Number of	or Rural Route Number,
Division of Vital Records,	or Attendate deat	Certification:	4 ☐ Homicide determined		fy)	reet, lactory, office		City or To	own, State)	
	To the Hospital or Ai within 24 hours after To the Funeral Direc completely filled in by		29a. Certifier 1 Certifying F	hysician: To the best of my kn aminer: On the basis of examin	owledge, deat	h occurred at the t	ime, date and place	e, and due to th	ne cause(s) and mann	er as stated.
	he Ho in 24 h he Fu	edical	one)	and manner stated.	allori arid/or ii			uned at the time		
	with the control of t	Σ	29b. Signature and title of certifier			29c. Licen:	S - ODO		29d. Date signed (M	
	10 cm		12014		om 00a) (5) - 000		October	19,2011
	0 0		30. Name and address of person wh	- Mana M.D.	om zoa, (Type	, . m.,	4940 I	Eastern A	Avenue, Balti	more, MD, 21224
		ate	31. Date filed (Month, Day, Year)	32. Reofstrar's Sign	ature					
	Regist	rar	ULI A T ZUII /CE	Mary 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month October 1°0 2011 William Long Medical 7:49 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) Months Days Hours Aug 29, Year 1943 1 🔯 M 2 🗆 F Director 68 unk 214-44-4770 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No MD Baltimroe Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 USA P.O. Box 10288 or items 11 Marital Status unk 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married unk 72 hours after 2 No Yes Maryland 21215-0036 If Yes, Give Year or Dates is marked other than "natural", aumatic event, the Medical Exal 1 Yes 2 No Specify: white 3 Divorced 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) unk 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. unk Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greater Baltimore Med Ctr 6701 N. Charles Street Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☒ Other (Specify) in state Kona I vice Wansee State and Address of Facility and 655 W. Baltimore Street Virector . Baltimore, MD 21201 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ulmonary Embolism disease or condition WILL Medical resulting in death) Due to (or as a consequence of): Examiner months S uentiall, list conditions if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events PATITIE UNKNOUN and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been shown to the control of the Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 ours after death. eral Director: After this certificate I filled in by the funeral director, pag performed 2 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🖸 No Other: 1 Unpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 2 Acciden
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 20056156 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204

Registrar
DHMH 17 Rev 7/2009

State

7anne

31. Date filed (Month, Day, Year,

Carrell

M.D.

Registrar's Signature

6565 NOVIM Charles Street

and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-07877 State of Maryland / Department of Health and Mental Hygiene Gary Wayne Lintz 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Lest) Physician/ Month Day October 19, 2011 2335 hrs **Medical Examiner** GARY WAYNE LINTZ 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death n/a Johns Hopkins Bayview Medical Center Baltimore B. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Hours Months Davs 01/01/1967 44 Director Country) M D 218-88-2360 1 X M 2 F Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b County 10a State 1 Yes 2 X No ROSEDALE BALTIMORE Mental Hygiene. narked other than "natural", or items 23a or 28s-f show event, the Medical Examiner must be softlified at soce. MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked ofter than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be ootffied at occe. Director 10f. Zip Code 10a. Citizen of What Country' 10e. Street and Number 21237 1404 CHESACO AVE 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No. Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' Never Married 2 Married Yes WHITE 1 Yes 2 X No specify: Specify If Yes, Give Year 3 Widowed 4 Divorced ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) DISABLED 21215-0036 DISABLED 8 n 18.Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) ELIZABETH NEVINS E. LINTZ SR. RONALD Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ MD CHESACO AVE BALTIMORE, MD 21237 LINTZ FATHER 1404 RONALD E. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 Burial 2 A Cremation 3 Removal from State 10/24/11 BALTIMORE, MD CREMATORY Department o
Important: |
injury or oth METRO Donation 5 Other Specify. 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licenses CHESACO AVE BALTIMORE, MD 21237 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical attending physician a or use as the burial -UNPENDED AMENDED The law requires that the death certificate be Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Day Year Month Live birth 3 Ectopic pregnancy Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknow the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o signed by à 1 Yes 2 No 3 Probably 4 Unknown σ. Completed Records, ficate has been s , page 2 should t 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 1 🗸 Yes No certificate 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical of Vital director, Be examiner? Other Nursing Home 5 Residence 6 Other Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 DOA this 1 Yes 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 27 Manner of Death Certification: Oct 19, 2011 Pedestrian struck by auto 2308 hrs 1 Yes 2 ✓ No Natural Division To the Hospital or Attendii within 24 hours after death.
To the Fuoeral Director: Pending filled in by the 2 🗹 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 2Be. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State)
Eastern Avenue and Virginia Avenue, Essex, Md. determined (Specify) Major Road / Highway 4 __ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number October 20, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner Ling Li, MD Censured Registrer's Sign

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month -37 0 Medical County of Death 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. Examiner MO 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral Min. 1 🛛 M 2 🗆 F Months Hours 1 (Month Day, Year) PENNSYLVANIA **Director** 85 198-20-3273 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City. Town or Location Director NOTTINGHAM BALTO. 1 Yes 2 No MD 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number Funeral USA 21236 4024 JACINTH WAY 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify. Specify. 3 Widowed 4 Divorced Completed Year or Dates.1944-1946 th and Mental Hygiene. 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4-or 5+) BENDIX SUPERVISOR Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ MARY E. MCKENZIE MILLARD R. LIVENGOOD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once, NOTTINGHAM, MD. 21236 4024 JACINTH WAY **SPOUSE** VERONICA LIVENGOOD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State TIMONIUM, MD. 11-21-2011 DULANEY VALLEY 4 Donation 5 Other (Specify) FUNERAL HOME 22. Name and Address of Facility SCHIMUNEK 21. Signature of Funeral Service Licensee 21236 NOTTINGHAM, MD. 9705 BELAIR ROAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ HIGH disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform 2 X No After this certificate 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Cath 28c. Injury at work?
1 Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury 5 Pending 2 🗌 No Accident Investigation filled in by the 24 hours after dea:
Funeral Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 201 on who completed cause of death (Item 23a) (Type, Print) Mariam State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ INEZ LUCILLE LEFKOWITZ ocTober 13, 2011 9:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST HOSPICE TOWSON BALTIMORE If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral . Social Security Number 7. Age (In yrs. last birthday) (Month, Day, Year) Days Hours Min Country) 220-42-7407 63 1 🗆 M 2 🕇 F Director 12/24/1947 MD Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director MD 1 Yes 2 X No HARFORD BEL AIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 23a Funeral 613 EMMY DEE DRIVE 21014 **IISA** or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White, etc. ò 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 WHITE 1 Yes 2 No Specify: "natural", 3 X Widowed 4 Divorced Completed Year or Dates. injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) College (1-4 or 5+) OUEST DIAGNOSTICS DRIVER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ JOSEPH MCELROY DEVONA WEDDLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra. LISA SCHWARZ-DAUGHTER 613 EMMY DEE DRIVE BEL AIR, Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 10/19/11 HILL MEM. GDN. BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC ▶ BALTIMORE, MD 21206 6415 BELAIR RD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician UNG ONTH disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Exami and that initiated events Due to (or as a consequence of): resulting in death) Last burial physician Physician/Medical Box 68760 the as attending IF FEMALE: nse 23d. Date of delivery 23b. Was decedent pregna 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 mon ō Month Day Year Pregnant at time of death 2 No the g Unknown g Unknown P.O. signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? Yes funeral director, 25. Was case referred to hedical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital 1 🗌 Yes 2 No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 within 24 hours after death.

To the Funeral Director: After this 28c. Injury at work?

1 ☐ Yes 2 ☐ No 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury Natural 5 Pending Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ho Yang Lin October 2011 16, 8:44 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery <u>Rockville</u> 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Days Hours **Director** 068-52-6617 90 1921 Taiwan September 1 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d Inside City Limits 1 🗌 Yes 2 💢 No Maryland | Montgomery North Potomac 10e. Street and Number 10g. Citizen of What Country? Funeral 20878 14731 Soft Wind Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 🗓 No If Yes, Give by 1 Never Married 2 Married 1 Tes 2 X No Specify: Completed 3 ▼ Widowed 4 □ Divorced Asian Year or Dates Maryland 21215-00 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chuan Yang I-Liang Lu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chihmei Chen/Daughter <u> 1622 Linway Park Drive, McLean, Virginia 22101</u> Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town. State October 24, cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium 4 Donation 5 Other (Specify) 2011 Bethesda, Maryland Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 Haran mail 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Severe disease or condition resulting in death) Medical Examiner Sequentially list conditions. cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: ည 1 Tyes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 24 hours after death.

Funeral Director: Al

Deted filled in by the fu 1 Yes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hor To the Fune completed fi 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier MD D0067386 October 16,2011 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville MD 20150 Sonia MD 9901 Medical ohn 31. Date filed (Month, Day, Year) State Registrar

xx0 0110c/01/0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Year 11:35 AM R. I.Ow Mary October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Bethesda Suburban Hospital Social Security Numbe If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🕅 F Days Hours Min (Month, Day, May 22. New York Ĩ925 Director 132-18-7110 86 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 X No Bethesda Maryland Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 9707 Old Georgetown Road 20814 death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify "natural", Completed 3 X Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 hand Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) the Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Lawrence McNamara traumatic Catherine O'Dea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other traumonce. 7561 Capilano Drive, Solon, OH 44139 Mark S. Low / Son 20a, Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State Receivery crematory or other place)
Montgomery
Crematorium, In October 19, 1

Burial 2

Cremation 3

Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Inc. 2011 21. Signature of Funeral Service Licensee Robert and Adrian free Funeral Home/Bethesda-Chevy Chase, Inc. toland for 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ovarian Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Jause (Disease or iirijury and that initiated events Due to (or as a consequence of) resulting in death) Last cate has been signed by the attending physician a page 2 should be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☑ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certificate Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗓 No Hospital Other: 1 🗌 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

ow, Mary R. 10/16/2011 11:35am

Medical

29a. Certifier

29b. Signature and title of certifier

Yuneng Li,

M.D.

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State Registrar Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D67986

29d. Date signed (Month, Day, Year) October 16, 2011

29c. License number

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

8600 Old Georgetown Road, Bethesda, Maryland 20814

CRNP

JONES,

18. Mother's Name (First, Middle, Maiden Surname) Ruth Edna Lindamood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 11810 Reynolds Road, Bradshaw, Maryland 21087 20c. Location - City or Town, State Date Harford Memorial Gdn 10-20-2011 Aberdeen, Maryland McComas Funeral Home, P.A. 22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009 Interval Between Onset and Death 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform 1 Yes 2 No 26. Place of Death (Check only one) 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) 28d. Describe how injury occurred 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🕱 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 201 rson who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32 Registrar's Signature ORIGINAL

2 Date of Death

October |

8. Date of Birth

(Month, Day, Year)

Min

33548

12:40 A M

9. Birthplace (State or Foreign

10d. Inside City Limits

1 🗌 Yes 2 🄀 No

2011

4c. County of Death

Sep. 11, 1927 Maryland

USA

Union

Baltimore

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

14. Race - American Indian,

White

Black, White, etc.

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and titl

JACKIE

30. Name and ad

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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nd 2 sh ealth ar n 27 is ier trau		Robert D.			_		801	River	Stra	and C	hesa	peake,	Vir	gini	a 23	320	_
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dispo	Cremation		om State	Ga Ga	Place of Disp semetery, cre te of	osition (Nam matory or ot Heave	e of her place n		Octo					Town, State	arulana
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pital o		29a. Certifier 1	V Certifying	Physician: To the				occurred at	the time	date and	I place a				oer se ets	ated	
To the Hospital or Attending Prystician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the by	Medical	(Check 2	Medical Ex	caminer: On the l	pasis of e	xamination	n and/or inve	stigation, in m	ny opinior	n, death o	ccurred at	t the time, date a	and pla	ce, and du	e to the c	cause(s) and m	anner stated.
To To t		29b. Signature and til	tle of certifier	a L	4			1	License					_		, Day, Year) 2011	
" XI P		30. Name and address	ss of person w	ho completed ca	ause of d	leath (Item	23a) (Type,	Drint\									20005
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State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature																	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1958 EMMANUEL MAYSON Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10 H HOSPITA CROSS SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. (Month, Day, 6. Sex 9. Birthplace (State or Foreign Country) **Funeral** 1 M M 2 D F Director Usual Residence of Decedent show 10a. State 10b. County be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MONTGOMERY COREEN BEI 10e. Street and Number 10g. Citizen of What Country? Funeral SPRING HILL 07 6000 TPA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 Divorced 4 Divorced Year or Dates. NA B1 MCK any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

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Late Anatomy Board 655 W. Baltimore Street Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RESPIRATORY FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ULTIONARY Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit PROM Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

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neral Director: A
filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature 29d. Date signed (Month, Day, Year) Mp 66686 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Gerri Baer, MD.

Day, Year) 2011

DHMH 17 Rev 7/2009

82. Registrar's Signature

1500 Forest Glen Rd. Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Minento 07 PM seraldine October 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore The Johns Hopkins Hospita iti In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 213-32-9573 Hours Min 76 1 🗆 M 2 💢 **Director** 8/22/35 MD Usual Residence of Decedent 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director MD N/A 28a-f Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r Funeral 1423 Covington Street 21230 USA items ? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Force Black, White, etc. 0 þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Yes 2 😾 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify "natural" **3** Widowed 4 □ Divorced White Completed ed other than "natu 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Service Bartender 8 U Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H 27 is marked of r traumatic even Edward Lewis 0 Leah Macintyre 19b. Mailing Address (Street and Number or Rural Houte Number, City of Town, 1423 Covington Street, Baltimore MD 21230 19a. Informant's Name/Relationship (Type, Print) Janice A. Creager/ Friend Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 10/25/201 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Baltimore MD 22. Name and Address of Facility Charles L. Stevens Funeral Home, 1 1501 E. Fort Avenue, Baltimore MD Signature of Funeral Service Licensee Victor P. Doda Sich 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DEDSIS disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or in that initiated events and the burial-trai Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Vear Day Pregnant at time of death signed by the at be detached for Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 X No after death.

Director: After this certificate 2 🗌 No 25. Was case referred to medica funeral director, To Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 2 🗌 No Investigation 6 Could not be Accident filled in by the 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital within 24 hours a To the Funeral C Medical

State Registrar 29a. Certifier (Check

29b. Signature and title of certifie

31. Date filed (Month, Day Year,

D. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

RES-000

600 N. Wolfe St Baltimore Maryland 21287

29d. Date signed (Month, Day, Year,

October 20 2011

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

			_ For	State of M	laryland	d / Depa	rtment of	Health and	Mental Hyg	iene		00550	
			State Registrar			Cen	tificate of	Death	R	eg. No.		33552	
	Dhysisis	/	1. Decedent's Name (First, Middl	le, Last)					2. Date of Deat		V	3. Time of Death	
4-	Physicia Medic		Alicia	Venegas		Mort	imer		October	17°,	20 ^{Year} 1	8:20 P M	
3	Examin	er	4a. Facility Name (if not institution	,				or Location of Deat	h		y of Death		
			Arden Courts 5. Social Security Number					er Spring	T		ontgor		
	Funeral Director		578-54-9331	6. Sex 7. Ag	ge (In yrs. las 95		Months Day	r If Under 24 Hrs s Hours Min.	(Month, Day,	Year)	Coun	**	
			Usual Residence of Decedent	1 - M 2 - 2 - 2 - 1	95	Yrs.			Aug. 15	, 1916	Co.	Lombia	
	land sho	ţo	10a. State 10b. County	/	10c. City,	, Town or Loc	ation				1	0d. Inside City Limits	
	Mary 28a-f otifie	Director	MD Mon	itgomery	<u> </u>		Silve	er Spring				1 ☐ Yes 2XXNo	
	h the	a D	10e. Street and Number				10f, Zip Code			10g. Citizen of	What Coun	try?	
	th with ms 23 must	Funeral	15320 Pine Or		1A			906		United	l Stat	tes	_
	r deat		11. Marital Status1 ☐ Never Married 2 ☐ Ma	12. Was Decedent Armed Forces?			as Decedent of Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	pecify Yes or No- to Rican, etc.)		ce - Americ ick, White, e		
3	s after al", c Exam	d by	3 Widowed 4 Divorce	16 Van Cive	No	1	☐ Yes 2 🛛 1	No Specify:		Specify	v: \	White	
5	hours natur iical I	Completed	15. Decede	ent's Education		16a. Decede	ent's Usual Occ	upation		16b. Kind of E	Business/Inc	dustry	
7	in 72 e. ian "ı Med	dmc	(Specify only high Elementary/Secondary (0-12)	nest grade completed) College (1-4 or :	5+)	(Give k	ind of work don NOT use retire	e during most of wo d)	rking			,	
7	withi giene ger th			3		Ed	itor			Interna	ationa	al Trade	_
2	I and 2 should be filed within 72 hours after death with the Maryland theath and Mental Hygiene. Theath and Mental Hygiene. It heath and Mental Hygiene is the matural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle,	,				1	me (First, Middle, M				
710	l and 2 should be file Health and Mental H tem 27 is marked of other traumatic ever	_	Pedro		laldon	ado		Maria	del Ca	rmen	Gai	czon	_
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ָר ע	and 2 Healt em 2 ther		German Venega 20a. Method of Disposition	s Maldonado/			Pine C	rchard Di				g, MD 20906)
5	Page 1 nent of ant: If it ury or o		1 🗌 Burial 2 💢 Cremation		ce	emetery, crem	atory`or other p			20c. Location	-		
	permit. Page Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (Che			tory 10/2				lle, MD	_
ב	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.	,		Elicensee		Į Ž	app Fun	ress of Facility eral and	Crematio	n Servi	ices	00010	
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	y the	nysi	1 ☐ Yes 2 ☒No 9 ☐ Unknown	9 🗌 Unknown			other (epochy)						
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5	ng P		27. Manner of Death 1 X Natural 5 ☐ Pendi	28a. Date of inju (Month, Da		28b. Time of injury	28c. Inj	ury at ork?	28d. Describe ho	w injury occur	red		
	tendi Jeath tor: A the fi	Certificate:		tigation				Yes 2 No					
2 3	or At after of Direct in by	Cert	4 Homicide deterr	mined 28e. Place of Inj	jury - At hon tc. <i>(Specify)</i>		et, factory, offic	е	28f. Location (St. City or Town		ber or Rural	Route Number,	
ָ נ	ione hospital or Attending Prysician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi		29a. Certifier 1 🛣 Certifyin	g Physician: To the best of	f my knowlo	edge death a	courred at the ti	me date and place	and due to the co-	ise(s) and mar	ner ac etat	ed	_
i	e Hoo 124 h e Fun letely	Medical	(Check 2 Medical	Examiner: On the basis of e By Nurse Practitioner: To the	examination	and/or investi	gation, in my op	nion, death occurred	at the time, date an	d place, and du	ue to the car	use(s) and manner stated	d.
	withir To the comp	2	29b. Signature and title of certifie		, 200 OI III	,		nse number		e cause(s) and 9d. Date signe			_
	(1		Shon				D2	28656		OCT	OBER :	18, 2011	
	D Can		30. Name and address of person	who completed cause of	death (Item :	23a) (Type, Pr	rint)					-	_
	J. U.		RAVI PASSI M.D	., 15245 SHA	DY GR	OVE RI	, #13O,	ROCKVILI	LE, MD	20850			
	Stat Registra		31. Date filed (Month, Day, Year)	1 2011 32. Registr	rar's Signatu		- 41						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 33553 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7:25P M oran 2011 Medical TODEY 4a. Facility Name (if not institution, Examiner give street and number 4c. County of Peath
Anne Hyunde Annu Saltimore washington Medical Center Glen Burnie **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **X**X M 2 □ F Months Hours (Month, Day, Yea 1 / 7 / 1963 Country) 219-82-2440 **Director** 48 Usual Residence of Decedent Department of Health and Merital Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Glen Burnie 1 ☐ Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 105 Ridgely Road 21061 USA 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes XX No Black, White, etc. þ 1 Never Married XX Married 1 Yes 3altimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Customer Service Rep. Maintenance Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles L. Moran, Sr. Patricia Batton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kathy Moran / Wife 105 Ridgely Road Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation ☐ Other (Specify) Griffith Family Cem. 10/21/2011 Severn, MD 21. Signature Furieral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 It 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Int 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ ence <u>days</u> Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Year Month Day Pregnant at time of death Yes 2 No the detached 9 Unknown 9 Unknown þ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I signed 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page 2 certificate 1 Yes within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 은 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 D Yes 2 D No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contributing Number Pranties on To the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contributing Number Pranties on To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contributing Number Pranties on To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contributing Number Pranties of the cause (s) and manner stated Contributing Number Pranties of the cause (s) and manner stated Contributing Number Pranties of the cause (s) and manner stated Contributing Number Pranties of the cause (s) and manner stated Contributing Number Pranties of the cause (s) and the cause (s) (Check only or 108 death (Item 23a) (Type inpleted cause of 31. Date filed (Month, Day, Year, 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rederick Neyh	art	State of Maryland / Department of H		-	20	33554
Physic	ian/	Registrar 1. Decedent's Name (First, Middle,Last)	Cath	Reg. 2. Date of Death	. No.	3. Time of Death
Filysic Medical Exam			VHART	Month [October 10,	Day Year	0105 hrs
		THE DEATER MELANTOUR NE	City, Town, or Location of Death		4c. County of Death	
			Carroll		Carroll	
Funeral	-	Social Security Number	If Under 1 Year If Under 24Hrs	. 8. Date of Birth	(MM/DD/YYYY) 9. Birt	hplace (State or
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				J4LY 9	1,1971	intry) VA
ny		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
W W						1 Yes 2 No
yland -fsb	호	MD CARROLL SYKES 10e. Street and Number	VILLE			
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15-0036 filed within 72 hou I Hygiene. od other than "nath t, the Medical Exa		17. Father's Name (First, Middle, Last)	18.Mother's Name		,	
21215 ould be fill Mental H marked	B	ROBERT JOSEPH NEY HART 19a. Informant's Name/Relationship (Type, Print) 5/5/FER 19b. Mailing Ar	MARY	KATHR	AN WEI	NTOSH
MD 21215-0036 11 should be filed within 7 th and Mental Hygene. 127 is marked other than umatic event, the <u>Medica</u>	유					
Nore, MD 2 sges I and 2 shou nt of Health and N t: If item 27 is no other traumatic		ANNA - KATHRINA LARSON 5729 20a. Method of Disposition 20b. Place of Dispositio	MIAMI CO	YRT E	LKRIDGE	mo 21015
Fe, lan filter filter friter er tra		1 Rurial 2 Cramation 3 Removal from State Crematory or other	place)	1 1		
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Baltimore, permit. Pages I as Department of He Important: If ite	10	4 Donetion 5 Other Specify: AROENT C 21. Signature of Funeral Services icensee Joseph L. CANBY 22. Nam	e and Address of Facility	ARTULIO	FUNERAL	CHAPFI
Balt permit Depart Impor	ı jı	Mal moco 18 1600				
Physician		28a. Part 5 te the disease, or complications that caused the death. Do not enter the r	node of dying, such as cardiac or	respiratory arrest	, shock, or heart	Approximate Interval
/Medical	/	ailus. List only the cause on each line.				Between Onset and Death
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ed sit	Exa	events resulting in death) Last Due to (or as a consequence of):				
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Box 68760 death certificate be the attending physical for use as the bu	ysic	1 Yes 2 No 9 Unknown 9 Unknown	(Specify)			
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ords, w require us been si should b	Completed			24a. Was an	I 24b. Were auto	opsy findings available
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been siled in by the funeral director, page 2 should the	를			autopsy performe	prior to co	mpletion of cause of
Vital Reco ysician: The law his certificate has director, page 2 s	ĕ			1 ✓ Yes 2		2 No
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ing Ph After t funeral		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how	v injury occurred	
ion tendi eath.	읉	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Yes 2 No			
VIS or At fler d Direct in by	ij	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fa	ctory, office building, etc.		et and Number or Rura	al Route Number, City
Divisipital or At ours after deral Direct	Certification:	4 Homicide determined (Specify)		or Town, State	e)	
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred	at the time, date and place, and	due to the cause(s	s) and manner as state	1.
To the Howithin 24 h To the Fur	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation,	in my opinion, death occurred at	the time, date and	d place, and due to the	cause(s)
Ļ.ž Ļ ģ	S	and manner stated. 29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Mont	h, Day, Year)
		lack him	O.C.M.E.		October 10, 2011	
		30. Name and address of person who completed cause of death (Item 23a)				
		Ling Li, MD Assistant Medical Examiner 900 W. Baltimore	Street, Baltimore MD 211	223		
	210	31. Date filed (Month, Day, Year) 32. Registrar's Signiflure				
Regis		OCT 2 1 2011 Person B. Market				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEN DITEM#17perFH, G922, 12/16/2011, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** OCT. MARGARET MARY O'CONNOR 18,2011 5:10 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN WOODS NURSING CENTER ROSEDALE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 JXF 216-20-1181 Director 85 NOV, 21, 1925 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show the notified at 28a-f show 1 Yes 2 No BALTIMORE NOTTINGHAM Director MD death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3802 WEAN DRIVE UNIT 2D 21236 USA ral", or Items 23a Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hyglene, 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) the NURSE US GOVERNMENT Is marked other 17. Father's Name (First, Middle, Last) Charles McMann 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental CHARLES N. O'CONNOR MARGARET ELIZABETH BROGAN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; if item 27 Is any Injury or other trau once. GERARD H. O'CONNOR-HUSBAND 3802 WEAN DRIVE UNIT 2D NOTTINGHAM, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages ' 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/25/2011 ST. JOSEPH CEMETERY BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME Kunya 6415 BELAIR ROAD BALTIMORE, MD 21206 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Immediate Cause (Final disease or condition resulting in death) Physician MOCREGI /Medical Due to (or at a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner asequence of) be executed burial-trai Due to (or as a consequence of): Box 68760. physician Physician/Medical death certificate the SE IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy page performed? es 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2**/2**No 2 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? To the Hospital or Attending Plantin 24 hours effer death.

To the Funeral Director Affer the completely filled in by the funera 27. Manner of Death 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

JUde

31. Date filed (Month, Day, Year)

1845

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

MD 32/Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death 2011 9:45 AMM <u>October</u> Kathleen Patricia Phillips 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 215 Larkspur Lane Middle River <u>Baltimore</u> If Under Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Min. Mary Land 1 □ M 2 🔀 F Months Days Hours 05/18/1942 214 40 3436 69 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🛣No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 215 Larkspur Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ☐ Yes 2 🗶 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Bowman Veronica Scheftel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Edmund Phillips (Husband 215 Larkspur Lane Middle River, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 10/22/2011 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland

Physician/ Medical **Examiner**

Physician/

Medical

10a. State

Examiner

Funeral

Director

or 28a-f show notified at

or than "natural", or items 23a or the Medical Examiner must be

permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonce.

Baltimore, Maryland 21215-0036

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Director

Funeral

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Completed

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the Maryland

physician at the burial-Physician/Medical attending p ed by the a been signatured beautiful to the second of t has within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of

To the Hospital or Attending Physician: The law requires that the death certificate be

Division of Vital Records, P.O. Box 68760

Ú.	21. Similar Service Elocal See	2	Bruzdz	inski Funera Id Eastern A	l Home PA Venue Ess	ex. Mary	land 21220
	23a. Patt 1. Enter the disease or complications shock or heart failure. Let only one Immediate Cause (Final disease or condition resulting in death)	cause on each line. Due to (or a a consequence of	ocial	F 10	or respiratory arrest,		Approximate Interval Between Onset and Death
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of					
ysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □XNo 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3			23d. Date of de Month	ollvery Day Year
ed by Ph	Part II. Other significant conditions com		in the underlying	cause given in Part I.			o the cause of death? Probably 4 Unknown
Complet					24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Be	25. Was case referred to medical examiner?			26. Place of Death (Che	ck only one)		
2	1 🗆 Yes 2 🛣No	ospital: 1	utpatient 3 🗆 D	OA Other: 4 Nursing H	Home 5 🕅 Residence	6 Other (Spec	cify)
ficate:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation		Time of graphinjury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred	
Medical Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	ırm, street, factor	y, office	28f. Location (Street a City or Town, Sta	and Number or Ru te)	ıral Route Number,
Medica	(Check 2 Medical Examine	cian: To the best of my knowledge, per: On the basis of examination and/or Practioner: To the best of my knowledge.	or investigation, in	my opinion, death occurred	at the time, date and pla	ce, and due to the	cause(s) and manner stated

29d. Date signed (Month, Day, Year)

State

Registrar

, Day, Year,

21

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eth (Item 23a) (Type, Prin

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 26 per verbal, g920, 10/21/2011dbb
Certificate of Death

Bea. No. For State Registrar 33557 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month a o II Beth Pau 0400 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Hours 1 - M 2 7 F Jan 4, Pennsylvania Director 184-50-2478 54 Usual Residence of Decedent 3a or 28a-f show t be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3512 Chestnut Avenue 21211 USA Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 💢 No þ Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give white Specify: 3 Widowed 4 Divorced Completed h and Mental rrygiene.
27 is marked other than "natural" Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 disabled none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 H. Garrett Paul Bertha Bachert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3900 Somerset Court Havre de Grace, MD Barbara Tartzyaski/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛱 Other (Specify) in state Signature of Euneral Source Licensee Rollar Rollar Director State and Attenty aboard 655 W. Baltimore Street Baltimore, MD 21201 Part Lepter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence or: disease or condition Medical resulting in death) Examiner ardiac ames Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for sels consecuence on the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? page 2 should be detached for Month Dav Year 1 Yes 2 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2.9 perform 2 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 8 Other (Specify Hospital 2 No ၉ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pendina ☐ Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The

State

31. Date filed (Month, Day, Year) Registrar **NCT 21**

29b. Signature and title of certifier

29a. Certifier

lospital Baltimore Union al Memori

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

atanasku

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

AT 2438946

29d. Date signed (Month, Day, Year,

mb 21218

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year , A, Parker oan 1:35 Stoper 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🗗 F Months Days Hours 216-12-6759 88 Yrs Nov. 05, 1922 Baltimore, MD. Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Baltimore County Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7601 Old Harford Road 21234 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 ☐ No Specify Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Glen L. Martins 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Parker Cecelia Jarciniski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Terry D. Mayne (Per.Rep./Exe.) 2214 Spring Lake Drive Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of Location - City or Town, State Evans Funeral Chapel and 1 Burial 2 Fernation 3 Removal from State Thursday, (Harford County) Cremation Services, Inc. 4 ☐ Donation 5 ☐ Other (Specify) oct. 20,2011 Forest Hill, Maryland 21. Signature of Funeral Service Licensee Jeffrey L.Gair, Sr. 1572. Name and Address of Facility. Peaceful Alternatives Funeral and Cremation Center, P.A. Lic.#M00677 2325 York Road Timonium, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ingestive Heart Failure disease or condition resulting in death) Septic Sy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Lectopic pregnancy Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

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28a-f s

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items 23a

a filed within 72 hours after al Hygiene.

other than "natural", or ite

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permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is
any Injury or other trau

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

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Funeral

Be Completed by

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death with the Maryland

or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, After this certificate has been signed by the funeral director, page 2 should be detached After this certificate

Examiner Physician/Medical Completed by Be Certification: To

Medical

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown

> 24a. Was an autopsy 2 **N**o 1 ☐ Yes

> > October, 19, 2011

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes

25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

RES 000

M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601 Loch Raven Boulevard, Baltimore, MD 21239

State Registrar 31. Date filed (Month, Day, Year) 21 2011

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32. Registrar's Signature

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neral Director: A
filled in by the fu

completely

To the Hospital within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 33559 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NORMAN A. PENCZEK OCTOBER 18,2011 7:00A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAINT JOSEPH MEDICAL CENTER TOWSON ${ t BALTIMORE}$ 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Director 219-22-1812 1X M 2 | F 84 3/13/1927 MARYLAND Usual Residence of Decedent shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD BALTIMORE PARKVILLE 1 Yes 2 No 10e. Street and Number 10f. Zip Code or 10g. Citizen of What Country? þe by Funeral 23a must ! 1766 JOAN AVENUE 21234 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Examiner Armed Forces? 1X Yes 2 If Yes, Give Black, White, etc. o 1 Never Married 2 X Married 2 No 1 Yes 2 No Specify. "natural", Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates. WWII Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the ELECTRICAN MANUFACTURING 11TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ ANDREW PENCZEK CATHERINE CIEPRISZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 LUCILLE PENCZEK/WIFE 1766 JOAN AVENUE BALTIMORE, MD or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/21/2011 GARDENS OF FAITH CEM. PARKVILLE, MD 21. Signature of Funeral Service Licensee MOO2 17 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. TOWSON, MD 8521 LOCH RAVEN BLVD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LACTIC ACIDOSIS disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Day Month Year Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RESPIRATORY FAILURE 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 2X No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 **X**No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No X Natural Accident filled in by the Investigation 24 hours after deatle Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

certificate be P.O. Box 68760 Division of Vital Records, Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

within 2

State Registrar

DHMH 17 Rev 06-2011

Medical

29a. Certifier

only one 29b. Signature and title

30. Name and address of person who

1 2011

TIMOTHY LOW, $M \bullet D \bullet$ Registrar's Signatur

cause of death (Nem 23a) (No. Print) RIVE TOWSON, MD 21204

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Pracettioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29c. License number

D24034

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | 33560 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month C 050 0850 M 14 Medical OI 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Howard Columbia Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Months Days Min. 1 □ M 2 💢 F Hours Director 216-23-1958 73 1938 Brazi Tan 6 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f showon; injury or other traumatic event, the Medical Examination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD Howard Ellicott City 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5320 Dorsey Hall Drive #427 21042 Brazil 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. <u>Ş</u> 1 Never Married 2X Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Antonio Romano Lucia Baggini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aristone L. Pereira/husband 5320 Dorsey Hall Dr. #427 Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) Final Journey Crematory 10/22/11 4 Donation 5 Other (Specify) Woodbine, MD 21. Signature of Funeral Ser Coing HOme Cremation Service P.O. Box 784 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause Fine! Clarksville MD 21029 Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani yocar din disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, ir any, reduing to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to ler as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed De ተes Mel and Due to (or as a consequence of) lш resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day 2 🖵 Yes signed by the a d be detached f 1 Yes 2 L 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 3 Probably 4 Unknown should 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy this certificate 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of Death 27. Mann 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending Accident Suicide Investigation 1 Yes 2 No M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cedar Lana WILIP 31. Date filed (Month, Day, Year) 0CT 2 1 201

DHMH 17 Rev 7/2009

State Registrar 32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 2011 P^{M} October Camille Oden Pace 14. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Takoma Park Washington Adventist Hospital Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral Days Min. 1 M 2 XF Months Hours 1928 Maryland Director 83 216-22-1528 eptember Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🔀 No Maryland Montgomery Bethesda 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number Funeral 5407 West Cedar Lane 20814 United States be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces?
1 ☐ Yes 2 XNo Black, White, etc. 9 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural" 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F ဂ္ Joseph H. Oden Vallie Daymude 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other trains 16009 Bonniebank Terrace, Darnestown, Maryland 20874 Valerie P. Bradshaw/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Page 1 October 2011 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland permit. Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service Licensee M01530 7557 Wisconsin Avenue, Bethesda, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final te Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant 5 Other (specify) Pregnant at time of death signed by the a Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed? has page 2 1 Yes 2 No this certificate Yes **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 No 1 Tes ပ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 28b. Time of 28d. Describe how injury occurred Certificate: To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After i 1 Natural iniury 5 Pending 2 No Accident Investigation filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. сопретен (Check only one) 29b. Signature and file of certific

State Registrar

GREGORY

31. Date filed (Month, Day, Year)

P.O.

Shady Grove Road Rockville, MAR-1/4N) 20550

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14.

Fisher

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33562 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 16, 5:25 P M Rayburn Willis Qualls, Jr. 2011 October Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** 1 🔀 M 2 🗆 F June 9, Year 1930 Tennessee 81 **Director** 415-62-0990 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🔀 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or than "natural", or items 23a or the Medical Examiner must be Funeral 11815 Hitching Post Lane 20852 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married 1 🔀 Yes þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates. 1952–1956 and Mental Hygiene.
is marked other than "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Senior Marketing Representative Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Department of Health and Menta Important: If item 27 is marked any injury or others. Rayburn Willis Qualls Love Mae Brandon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Joan Qualls/Wife 11815 Hitching Post Lane, Rockville, Maryland 20852 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Gate of Heaven
Cemetery October 20 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2011 Silver Spring, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Maryland 20850 Montgomery Avenue 21. Signature of Funeral Service Licensee M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicien/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Bacteremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or iinjury Chronic Lymphocytic Leukemia attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month 5 Other (specify) Pregnant at time of death signed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🗌 No 3 🗍 Probably 4 🏝 Unknown Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Thrombocytopenia page 2 s autopsy performed?

1 Yes 2 No death? 1 ☐ Yes 2 ☐ No this certificate of Vital 25. Was case referred to medical 26. Place of Death (Check only one) or Attending Physician: Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA ဂ္ 28a. Date of injury (Month, Day, Year) 28b. Time of filled in by the funeral 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director; After work?
1 Yes 2 No injury 1 X Natural 5 Pending Division Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. сотріете only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D\$\$6816\$ 10/17 gr. 30. Name and address of per on ho completed cause of death (Item 23a) (Type, Print)

State

Registrar

0

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32. Registrar's Signature

8600 Old Georgetown Road, Bethesda, Maryland 20814

Zuzak, MD

2 1 201

Kimberly B.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #17 Pewr FH C920 10/21/2011 JH
state of Maryland / Department of Health and Mental Hygiene amend item 28b per me g921 11-4-11 vt

Certificate of Death State
Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 18 Year 9:25 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Somertora Frederick Frederick If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🕱 M 2 🗆 F 122 12 874 96 Months (Month, Day, Year) Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Frederick Middletown 1 Yes XX No 10e. Street and Number 203 Cone Branch Drive 10f. Zip Code 10g. Citizen of What Country? Funeral 21769 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give White 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Draftsman General Electric Co. Be 17. Father's Name (First, Middle, Last)
Leonard Ruso
Leonardo 18. Mother's Name (First, Middle, Maiden Surname) Ruscitto ည Concettina Listorti 19a. Informant's Name/Relationship (Type, Print)
Lucie Ruscitto / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 203 Cone Branch Drive, Middletown MD 21769 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
St. John's Cemetery 1 Durial 2 Cremation 3 Removal from State 1/22/11 Schenectady, NY 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service LicenseeVictor Doda Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 OD 23a. Part 1. Enter the disease, or co ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) cranial Intra hemmyshoge Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): AMINER been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury PPROVED BY ME that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical CERTIF Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Day Pregnant at time of death Month Year g Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 1 X Yes 2 □ No Other: 4 Nursing Home 5 Residence 6X Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2🔏 No 28b. Time of Certificate: 28d. Describe how injury occurred Living Facinh 1 Natural unknown 5 Pending 2X Accident 28e. Pl ce of njury - At home, farm, street, factory, office building, etc. (Specify) Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Drive rederick m Somer tord ALF Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the only one 29b. Signaru **a So**d title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51643 10.18-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Thonson & Frederice MD 21702 en V 5hah iled (Month, Day, Year) 65 C State 21 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 | |

			For State of Marylar State of Marylar Registrar		tificate of D			leg. No. 2011	33564
	Physicia	ın/	Decedent's Name (First, Middle, Last) Darla Carol Ruley				2. Date of Deat	. 13, 2011	3. Time of Death 8:06 A M
	Medic Examin	al	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	october	4c. County of Dea	
			207 A Crocker Drive		Bel Air			Harford	
34	Funeral Director		5. Social Security Number 214-40-6824 Usual Residence of Decedent 6. Sex 1 □ M 2X F 69		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug. 30	Year) 1942 g. Bi	rthplace (State or Foreign ountry) Maryland
	land show dat	ē		ty, Town or Loc	ation				10d. Inside City Limits
:	28a-f	Director		el Air					1X Yes ⅓ ☑ No
:	orth the 23a or st be r		10e. Street and Number 207 A Crocker Drive		10f. Zip Code 21014			10g. Citizen of What C	ountry?
:	teath w	Funeral	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. W	Vas Decedent of His Yes, specify Cubar		ecify Yes or No-	14. Race - Am	
200	I and z should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Yelleath and Mental Hygiene. Yelleath and Mental Hygiene. Other traumatic event, the Medical Examiner must be notified at	ted by	1 Never Married 2 Married 3 Vidowed 4 Divorced 1 Yes, Give Year or Dates,		Yes 2 X No		rican, etc.)	Black, Whi	nite
5	72 hou n "nat ledica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupa ind of work done do NOT use retired)	tion uring most of work	ing	16b. Kind of Business	Industry
7 7	within giene. er thai , the N		Elementary/Seconday (0-12) College (1-4 or 5+)	1	emaker			Own Home	9
	e filed ital Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam			
3	ould by marke marke imatic	-	William Thomas Parker 19a. Informant's Name/Relationship (Type, Print)	19h Mailin	a Address (Street a		(nmn) W	Iillard City or Town, State, Z	in Code)
M	d 2 sh alth ar n 27 is er trau		David M. Ruley / Son					e, Maryland	
บ์ 5	permit. Page 1 and 2 si Department of Health a Important: If item 27 is any injury or other tra once.		1 Burial 2 Cremation 3 Removal from State	cemetery, crem	sition (Name of natory or other place	9)	1	20c. Location - City of	
	artmen ortant: njury		4 Donation 5 Other (Specify) 21. Signature Fulleral Servicy I icensee		Name and Address				Maryland
0	Depar Impor any ir		21. Signature Properal Service Licensee					Funeral Ho don, Maryl	
P	nysician/	01	23a. Part 1. Enter the disease, or complications that caused the dear shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition						Approximate Interval Between Onset and Death
3	Medical Examiner		resulting in death) a. Due to (or as a consequence)	uence of):	- Cara	9			
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence)	Steps	2m	physer	men		geers
704	d ansit	Examiner	cause. Enter Underlying Cause (Disease or iirijury that initiated events c.						
20	physician and the burial-transit		resulting in death) Last Due to (or as a consequence)	uence of):					
	physic s the b	edical	d						
or Attending Dissiples. The law sequines that the death codes	he attending ped for use as t	sician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 2 No g ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of g ☐ Unknown	al death 3 🗌	Ectopic pregnancy Other (specify)	1		23d. Date of d Month	elivery Day Year
; {	led by the detached	/ Phy	Part II. Other significant conditions contributing to death but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Did tol	bacco use contribute t	to the cause of death?
do, r	n signe	ed by					1 X Y	res 2 □ No 3 □	Probably 4 🗆 Unknown
	as been si	Completed					24a. Was a		utopsy findings available completion of cause of
	icate h		OF Mean and referred to medical				perform	med? death? 2 No 1 ☐ Ye	es 2 No
	is certifical	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	EB/Outpatien	. Otho	r:		ence 6 🗆 Other (Spe	orifu)
O III	th.: :: After this e funeral c		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28b. Time of injury	28c. Injury work?	at		ow injury occurred	City
DISIAN PROPERTY.	of the nospitar of Atlenton within 24 hours after death. To the Funeral Director: Α completed filled in by the the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At h building, etc. (Specification)		et, factory, office		28f. Location (St City or Town	treet and Number or R n, State)	ural Route Number,
a though or	n 24 houn n 24 houn ne Funera pleted fille	Medical	29a. Certifier (Check chief only one) 1	on and/or investi	igation, in my opinion	n, death occurred a	t the time, date an	nd place, and due to the	e cause(s) and manner stated.
1	Withi Con		29b. Signature and title of certifier		29c. License	number 5660 =	7	29d. Date signed (Mon	th, Day, Year) 17 20/1 R MI) 2/0/2
			30. Name and address of person who completed cause of death (Iten	n 23a) (Type, Pr	rint)	1.0.	LD	SEL AZ	R MID 2101
	Stat Registra		31. Date filed (Month, Day, Year) 33. Registrar's Signa	ature for	Alas Ro	7 , 544			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Dep			2011	33565
	-	Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	2. Date of Death	g. No.— U	3. Time of Death
Physici Medi		Valerie Faye Stracke		October	20, 2011	2:23 P M
Exami		4a. Facility Name (if not institution, give street and number) Stella Maris	4b. City, Town, or Location of Death Timonium		4c. County of Death Baltimor	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	g, Birthp	place (State or Foreign
Director		212-42-7078 1 D M 2 🕱 F 65 Yrs.	Months Days Hours Min.	(Month, Day, Y	(ear) Coun	try)
ind show at	'n	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation	107.07		0d. Inside City Limits
Maryla 28a-f s otified	rect	Maryland Baltimore Middle Ri	iver			1 🗆 Yes 2 🔀 No
th the	al D	10e. Street and Number 6904 Circle Road	10f. Zip Code 21220	10	g. Citizen of What Coun	try?
eath wi ems 2 ems 2	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	14. Race - Americ	an Indian,
flaryland 21215-UU36 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show "aumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ※ Married	If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 □XNo Specify:	Rican, etc.)	Black, White,	etc.
Ours a atural atural cal Ex	eted	3 Wildowed 4 Divorced Year or Dates.	dent's Usual Occupation	1.1	6b. Kind of Business/Inc	ite
Z15 in 72 h e. nan "n	Completed	(Specify only highest grade completed) (Give	kind of work done during most of work O NOT use retired)	ing	ob. Kind of Business/lin	lustry
d with dygien ther the	Be Co	11 Homer 17. Father's Name (First, Middle, Last)		/F:	Own_Home_	
be file ental Hed of	TO E	Woodrow Chesser		ne (First, Middle, Ma McMullen	iden Surname)	
nore, Maryland Z1Z15-5-UU36 age 1 and 2 should be filed within 72 hours after int of Health and Mental Hygiene. t: If tiem Z7 is marked other than "natural", o r or other traumatic event, the Medical Exam		 	ng Address (Street and Number or Rur	al Route Number, C	ity or Town, State, Zip C	(ode)
			Circle Road, Bal			
Baltimore, N permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other 2 once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	matory or other place)		0c. Location - City or To	
altin mit. Pa partme sortan / injury		4 Donation 5 Other (Specify) 21. Signature Fund Single Licensee	Valley Mem. 10/2 2. Name and Address of Facility Bruzdzinski 407. Old Fastorn A	5/2011 I	Baltimore,	Maryland
	1	1366	Bruzdzinski 407 Old Fastern A	Funeral venue, Es	Home,P.A. ssex, Maryl	and 21221
		23a. Partarter the disease, or complications that caused the death. Do not ent show, or heart failure. List only one cause on each line. Im_ediate Cause (Final)	er the mode of dying, such as cardiac	or respiratory arrest	t,	Approximate Interval Between Onset and Death
⊸Physician Medical		c ease or condition resulting in death) COLON CANCER Due to (or as a consequence of):				Office and Death
Examiner		Sequentially list conditions, b.				_
ed sit	Examiner	if any, leading to immediate cause. Erriter Underlying Cause (Disease or injury)				
xecute	Exal	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical	d	·			
ertificated in the second second in the seco	/Me	IFFEMALE: 23b. Max decadest present 23c. If yes, outcome of pregnancy				
box death or ne atten ed for u	Physician/Me	in the past 12 months? 1 \(\text{Live Birth} \) 2 \(\text{Fetal death} \) 3 \(\text{1 \text{Ves}} \) 2 \(\text{X} \) No 4 \(\text{Pregnant at time of death} \) 5	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
ut the d at by the etache	Phys	g ☐ Unknown		T		
Sy Tres that signed d be do	þ	Part II. Other significant conditions contributing to death but not resulting in the	andenying cause given in Part I.		icco use contribute to th s 2 □ No 3 □ Prot	
ecords, e law requires has been sig	Completed			24a. Was an		osy findings available
HeC The law cate has	J mo			autopsy perform 1 Yes 2	ed? death?	mpletion of cause of
VITAI ysician: is certific director,	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec	k only one)		
OT V ig Phys ter this or	e: To	1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time of	nt 3 □ DOA	ome 5 Residen 28d. Describe how	ce 6 X Other (Specify injury occurred	HOSPICE
ending eath. or: Afte	ficat	1 X Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No			
or Attendii or Attendii after death. Director: Al	Certificate:	3 ☐ Suicide 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
DIVISION OF VITAL RECC To the Hospital or Attending Physician: The law within 24 hours after ceath. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death				
the Ho hin 24 the Fu	Mec	(Check 2 Medical Examiner: On the basis of examination and/or investing only one) 3 X Certifying Nurse Practitioner: To the best of my knowledge	, death occurred at the time, date and pl	ace, and due to the	cause(s) and manner as s	stated.
1 Wit		29b. Signature and title of certifier	29c. License number 17 111479	29	d. Date signed (Month, I	Jay, Year)
1		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		10/20/2	~!]
H		JACKIE JONES, CRNP 2300 DULANEY V	ALLEY RD. TIMONII	JM, MD 21	093	
Sta Regist		31. Date filed (Month, Day, Year) OCT 2 1 2011 Agree A.				

DHMH 17 Rev 06-2011

11-07815 Lazaro Saumell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

azaro Saumell		State of Maryland / Department of Health and Notes 1- For State Certificate of Death Registrar	Mental Hygi	iene Reg.	201	33566
Physicia Medical Examir	ın/	1. Decedent's Name (First, Middle, Last) Lazaro F. Saumell	1	Date of Death	Day Year	3. Time of Death 0540 hrs
yeara.		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Local		7010001 10,	4c. County of Deat	
Funeral		Laurel Regional Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If	f Under 24Hrs. 8.	. Date of Birth	(MM/DD/YYYY) 9. Bir	thplace (State or
Director			Hours Min.	Oct 5,	1958 Forei	gn puntry) WV
Ď.	ļ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
nd show as		MD Howard Columbia				1 Yes 2 No
Maryland 28a-f show	Director	10e. Street and Number 10f. Zip Code			. Citizen of What Cou	ntry?
with the Maryland ns 23a or 28a-f sho be notified at once		10622 Hunting Lane 21044 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispani	nic Origin? (Specif	V Yes or No-		ican Indian, Black,
death w	Funera	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Me			White, etc.	
s after	à	3 Widowed 4 K Divorced If Yes, Give Year 1 X Yes 2 No sponsor 15, Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (· Cubai		Specify: Whi	
72 hour	eted	Elementary/Secondary (0-12) College (1-4 or 5+)				,
5-0036 iled within 72 hours a Hygiene. I other than "natura the Medical Examin	Completed	10 Jockey 17. Father's Name (First, Middle, Last) 18.N	Mother's Name (Fir		Thoroughb	red Racing
	Be C	The state of the s	anet Bens			
imore, MD 2121 Pages 1 and 2 should be fi ment of Health and Mental tant: If item 27 is marked or other fraumatic event,	리	19a. Informant's Name/Relationship (Type, Print) Janet B. Saumell/mother 19b. Mailing Address (Street and 10622 Hunting Letter)				e, Zip Code)
e, MC and 2 s Health au item 27	H	20a. Method of Disposition 20b. Place of Disposition (Name of cemete			20c. Location - City o	Town, State
Baltimore, Jepartment of Heal Important: If iten		4 Donation 5 Other Specify: Final Journey Cremat			Woodbine,	
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		21. Signature of Funeral Service Licens 22. Name and Address of F	Facility remation	Servic	ce P.O. Bo	ox 784
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such failure. List only one cause on each line.	eckrotte in as cardiac or re	D A spiratory arres	Clarksvil	proximate Interva Between Onset and
Medical Examiner		Immediate Cause (Final disease a. Atherosclerotic Cardiovascular	Disease			Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
	ine	if any, leading to immediate cause. Enter Underlying Cause				
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
0, be executed sician and burial - transit	dical	☐ AMENDED 23a,27,per me,g920 10-26	-11 sm			
68760, certificate bo nding physic		IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E	Ectopic pregnancy	,	23d. Date of deliver	y Day Year
Box 68760 e death certificate the attending physical for use as the bu	Physician/M	past 12 months? 4 Pregnant at time of death 5 Other (Specify)				
2 2		Part II. Other significant conditions contributing to death but not resulting in the underlying cause giver	n in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safer death. al Director: After this certificate has been signed by the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached.	ð Ç			1 Yes		bably 4 V Unknown
cords, aw requir	Completed			24a, Was ar autopsy perform	y prior to ned? death?	utopsy findings available completion of cause of
Vital Rec ynician: The his certificate director, page		25. Was case referred to medical 26. Place of I	Death (Check only	1 Yes 2	No 1 ✓ Y	es 2 No
Vita hyrician this cer	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Oth	ner Nursing H	lome 5 R	tesidence 6 Othe	or:
ion of tending Pheath. tor: After the funeral		27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at 1 Yes	2 No	d. Describe ho	ow injury occurred	
ivisio	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office build	ding, etc. 28f			ural Route Number, City
Divis spital or At nours after d neral Direct filled in by	Certification:	4 Homicide determined (Specify)	1	or Town, Sta		
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the it	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date a wind one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de	and place, and due eath occurred at th	e to the causer re time, date ar	(s) and manner as sta nd place, and due to t	ted. he cause(s)
To viii	Mec	29b. Signature and title of certifier 29c. License nu			29d. Date signed (M	
	ļ	O.C.M.E	E.		October 19, 201	1
7 Em		 Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Ba 	altimore, MD 2	21223		
St Regist	ate	31. Date filed (Month, Day Year) 32. Registrat's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ October 19, 2011 Lee Simms 8:20 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard Columbia Gilchrist Center 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** July 26, 1934 Washington, D.C Months Days 77 Director 578–42–7688 Jsual Residence of Deceden th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State death with the Maryland Director 1 🗆 Yes 2 😾 No Ellicott City MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21043 3675 Mt. Ida Drive #200 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Completed by and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Improvements Painter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Frances Rye John Wade Simms 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3675 Mt. Ida Drive #200 Ellicott City, MD 20143 19a. Informant's Name/Relationship (Type, Print) Barbara Simms/wife Health a injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State Final Journey Crematory 10/21/11 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signa re of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Head and Neck Cancer Due to (or as a consequence of) ears disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): for use as the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Pregnant at time of death 2 🗌 No 1 L Yes 2 L 9 L Unknown g Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed | rector, page 2 should be det Be Completed by Lymphoma 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available Cerebrovascular accident prior to completion of cause of death? performed 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2√2 No funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Wother (Specify) HOSDICE မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Medical Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 10/20/11 000606 34

State Registrar

DHMH 17 Rev 7/2009

COLUMBIA MD

LANE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336

UDSEPH

31. Date filed (Month, Day, Year)

OCT 2 1 201

CEDAR

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		-	For State Registrar	Otato	or ivialylal		rtificate			Qi i Qi		Reg. No.			
	Dhysisis	m/	1. Decedent's Name (First, Mid	dle, Last)							2. Date of Dea		Yea	3. Time	of Death
	Physicia Medic	al	William Jose								October				P ^M
*	Examin	er	4a. Facility Name (if not instituti		mber)		1		Location	of Death			County of D arfor		
-	-	77	121 Fairmont 5. Social Security Number	Dr.	7. Age (In yrs.	last hirthday)	If Under	Air 1 Year	If Under	24 Hrs.	8. Date of Birt			Birthplace (State	e or Foreign
	Funeral Director		217-22-5922 Usual Residence of Decedent	1 🙀 M 2 🗆 F			Months	Days	Hours	Min,	7/24/19			Country) MD	
	ryland -f show ied at	Director	10a. State 10b. Cour	nty		ty, Town or Lo	cation							10d. Inside	City Limits
	r 28a notif		MD Ha. 10e. Street and Number	rford	Be	1 Air	10f. Zip	Code				10a. Citiz	en of What		X
	vith th	ıral	121 Fairmont D	r.				014					USA	,	
	eath v	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U.	.S. 13.			spanic Or	igin? (Spe	cify Yes or No- Rican, etc.)	1-		merican Indian,	
036	s after d ral", or i Examin		1 ☐ Never Married 2 🙀 M 3 ☐ Widowed 4 ☐ Divord		s 2 🔀 No ive		1 Yes				noari, cto.,	s		/hite, etc. White	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	(Specify only his	dent's Education ghest grade complete		(Give	dent's Usua kind of wo	k done d	ation Iuring mos	st of worki	ng	16b. Kin	d of Busine	ess/Industry	
212	within giene. er tha the l		Elementary/Secondary (0-12	2) 2 College	(1-4 or 5+)	S	uperv	isor				Met	al Co	mpany	
nd	filed all Hyg) Be	17. Father's Name (First, Middle	e, Last)					18. Moth	ner's Name	e (First, Middle,	Maiden Si	urname)		
yla	ild be Ment narke	욘	George Sauerwe			_		1			ne Baco				
Mar	d 2 shou alth and 27 is m er traum	j	19a. Informant's Name/Relatio David Sauerwei								Route Number artstov				
Baltimore,	of He If item	ì	20a, Method of Disposition	on 3 Removal fro		Place of Dispo cemetery, cre	osition (Nar matory or c	ne of ther plac	e)		Date			y or Town, State	
Ē	:. Pag tment tant: jury c		1 Burial 2 X Cremation 4 Donation 5 Othe		At	lantic	Crem	ator		10/24				ie, MD	ol Air
Bai	permir Depar Impor any ir once.		21. Signature of Funeral Service	all		6	10 W.	Mac	Phai	1 Roa	ad Bel	Air,		ome of E /land 21	
			23a. Part 1. Enter the disease shock, or heart failure. Li	or complications that st only one cause on	t caused the dea	ith. Do not ent	er the mod	e of dying	g, such as	s cardiac o	r respiratory ar	est,		Approxir Interval E Onset ar	Between
	Medical		Immediate Cause (Final disease or condition resulting in death)	a	Property	Kin.								Oliset al	lo Death
	Examiner		Tobalang in dodain,	Due to	o (orio) a consec	and the one	116								
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or a a consec	uence of):		-				-		-	
	uted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	S	army		try	d	Kas	\sim					
	cate be executed physician and s the burial-transit		resulting in death) Last	Due to	o (or as a consec	querice of):	'	·							
200	ate be ohysic the bu	edical		d											
			IF FEMALE: 23b. Was decedent pregnant		utcome of pregr							2	3d. Date o	f delivery	
Вох	ss that the death certificing igned by the attending be detached for use a	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No		e Birth 2 Fe egnant at time of		Ectopic Other (s)		:у				Month	Day	Year
P.O. E	it the c I by th etache	Phys	9 Unknown Part II. Other significant cond			eulting in the	underlying	cause div	en in Pari	+ I	23e Did to	phacen us	e contribu	te to the cause of	of deat l /?
Is, P.	uires tha n signed uld be d	ed by	Tartii. Other significant cone	The state of the s	404011041104110									Probably 4	
Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours atter death. Of the Funeral Director, After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	Completed									24a. Was autoj perfo	osy rmed?/	prio dea	e autopsy finding r to completion of th?	gs available of cause of
ž	nysician: The law nis certificate has b I director, page 2 s		25. Was case referred to edic	cal			_	26 PI	ace of De	ath (Check	1 Yes	2 No	1	Yes 2 No	
Vita	ysicia s cert direct	To Be	examiner? 1 Yes 2 No	Hospital:	- ☐ Inpatient 2 🖺	☐ ER/Outpatie	ent 3 🗆 D	Othe	er:		me 5 Resid	dence 6	Other (5	Specify)	
Division of Vital	tending Physicath. or: After this the funeral di		27. Manner of Death 1 ✓ Natural 5 □ Per	28a. Dat	e of injury onth, Day, Year)	28b. Time of injury	of 2	8c. Injun work	? _	_	28d. Describe h	now injury	occurred		
sior	I or Attend after death Director: A	Certificate:	3 Suicide 6 Co	estigation uld not be 28e. Place	ce of Injury - At h	nome, farm, st	M reet, factor		Yes 2 L	⊒ No	28f. Location (S	Street and	Number o	r Rural Route No	umber,
DIV	tal or / s after al Dire ed in b		4 Homicide det	ermined 206. Flatbuil	ding, etc. (Speci	fy)	_				City or Tov	vn, State)			
	To the Hospital within 24 hours a To the Funeral Completely filled	ledical	(Check 2 Medic	ring Physician: To the al Examiner: On the bring Nurse Practition	asis of examinati	on and/or inve	stigation, in	my opinio	on, death o	occurred at	t the time, date a	and place,	and due to	the cause(s) and	manner stated.
	To the within To the Comp	Σ	29b. Signature and title of cert			,	1		e number	/			signed (N	fonth, Day, Year)	
	ŀ		111501 9	MAV ,	upo of dooth /lt-	m 22a\ /Tim-	Drint\	711	0 11			10	201	3	
)			30. Name and address of pers	on who completed ca	use of death (Ite	MV)	NO	14c						
Ī	Sta Registr		31. Date filed (Month, Day, Yea		Registrar's Sign	aturg.	back	/			•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26perpHYS G920 10/21/2011 WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar 33569 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 152011 4:55A M Louise Saynuk Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Glen Burnie 401 Ferndale Avenue 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Months Hours Min. Director 1 □ M 2**X**□ F 188-01-3664 Yrs Pennsylvania 97 09/06/1914 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director Maryland Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō iral", or items 23a o Examiner must be Funeral USA 401 Ferndale Ave 21061 death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) by 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 hours after Specify. Wh<u>ite</u> If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Health Care Secretary traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumation once. 2 Theresa Lentes George Spohrer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Ferndale Ave Glen Burnie, MD 21061 Ms. Loretta Parker/ Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 10 Date 18 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Baltimore NTL. Cemetery 2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySingleton Funeral & Cremation Signature of Funeral Sen Services 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 6 months disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine s a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Pregnant at time of death 1 Yes 2 L g Unknown Yes 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 Inpatient 2 XER/Outpatient 3 IDOA ျာ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 29c. License number 29d. Date signed (Month, Dav. Year) ature and title of certifier D0056046 108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive, Suite 210, Glen Burnie MD21061 203 Hospital atricia Gao 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland / De	partment of He	ealth and M				00570
		1	State Registrar	C	ertificate of D	eath	2. Date of Deat	eg. No.2	1	3. Time of Death
	Di data		. Decedent's Name (First, Middle, Last)	C 1 d				1 ¹ 9 ^y , 20	Year II	8:05 a M
	Physician Medic	اد	Anna	Sigmund	4b. City, Town, or I	ocation of Death	00000	4c. County of		
	Examin	-	a. Facility Name (if not institution, give stre		Glen Bur			Anne	Arun	del
and the		5	310 Scotts Manor Dr Social Security Number 6. Sex	7. Age (In yrs. last birthda	v) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Vear	9. Birth	place (State or Foreign
	Funeral Director	١		M 2 X F Yrs	Months Days	Hours Min.	August			Poland
			Usual Residence of Decedent	74 10c. City, Town or	Location		nagase	_,_,_,		10d. Inside City Limits
	/land f sho ed at	ig	MD 10b. County Anne Aru		Burnie					1 Yes 2 No
	28a-	Director	MD Anne Aru	nder Gren	10f. Zip Code			10g. Citizen of V	Vhat Cou	intry?
	th the 3a or t be r		310 Scotts Manor D	rive	2106	1		U	J.S.A	١.
	e filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral		. Was Decedent Ever in U.S.	3. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No- Rican, etc.)		e - Ameri k, White,	can Indian, , etc.
တ	er der or ite miner	by F	1 Never Married 2 Married	Armed Forces? 1 Yes 24 No If Yes, Give	1 Yes 2 XNo			Specify:	Whi	lte
Š	ırs aft ural", I Exa	ed	3 🕅 Widowed 4 🗌 Divorced	Year or Dates.	ecedent's Usual Occupa			16b. Kind of Bu	usiness/l	ndustry
5-	"nat	Pe	15. Decedent's Educ (Specify only highest grade	completed) (G	live kind of work done on e. DO NOT use retired)	during most of worl	king			
121	thin 7 ene. than he M	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	Homemake					Home
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<u>la</u> n	d be fi denta irked tic ev	유	557	loszuk		Anton		Mart		
ary	should be file and Mental b 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Type		Mailing Address (Street a	and Number or Ru	rai Route Numbe #012	r, city or 10wii, s Δ1exandi	ria.	VA 22307
Σ	ealth m 27		Ms. Angela Sigmur	20h Blace of F	Disposition (Name of		Date	20c. Location	- City or	Town, State
ore	age 1 and 2 should be int of Health and Ments t. If item 27 is marked or other traumatic e		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R	cometen/	crematory or other place drew Orthog	oe) dox 10/2	24/2011	Dunda	alk,	MD
Baltimore,	rt. Pag rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses		22. Name and Addre	ss of Facility 1	2nd Aven	ue SW (Glen	Burnie, MD
Bal	permit. Page 1 a Department of F Important; If ite any injury or ot		Do somo It.	11 moly 79	Singleton	n Funeral	L & Crem	ation S	ervi	ces, PA
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only one	cations that caused the death. Do no	t enter the mode of dyir	ng, such as cardiad	or respiratory ar	rest,	d	Approximate Interval Between Onset and Death
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€	Medica		resulting in death)	Due to (or as a consequence of):					
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9249	icate g phy: as the	Medi						2015		elistan (
89	certificate ending phy use as the	an/	IF FEMALE: 23b. Was decedent pregnant	 3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 	3 Ectopic pregnar	ncy			Date of de Month	Day Year
Box	requires that the death certificate been signed by the attending phys should be detached for use as the	Completed by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at time of death 9 Unknown	5 Other (specify)					
	at the	Phy	Part II. Other significant conditions co	ntributing to death but not resulting in	the underlying cause (given in Part I.	23e. Did	tobacco use co		to the cause of death?
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oce	sician: The law no certificate has the director, page 2 s	du					per 1 🗆 Yes	formed?	death?	es 2 No
Ä	n: The fficate or, pa				26.	Place of Death (Cl				
/ita	ysician: s certific director,	To Be	examiner? 1 🗌 Yes 2 🗖 🙀	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	tpatient 3 L DOA	ther: 4 Nursing		sidence 6 🗆 O		ecify)
of	g Phys ter this neral di	[<u>:</u>	27. Manner of Death		ime of 28c. Inj	ury at ork? □ Yes 2 □ No	28d. Describe	e how injury occi	Tued	
U	endin eath. or: Afi the fu	ifica	2 Accident Investigation 3 Suicide 6 Could not be				28f. Location	(Street and Nur	nber or f	Rural Route Number,
Division of Vital Records,	or Att ifter d jirect in by	Certificate:	4 Homicide determined	building, etc. (Specify)	mi, stroot, ractory, eme		City or T	own, State)		
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.			sician: To the best of my knowledge,	death occurred at the t	ime, date and plac	e, and due to the	cause(s) and ma	anner as due to th	stated. ne cause(s) and manner state
	e Hos n 24 h re Fun oletely	Medical	(Check 2 Medical Exami only one) 3 Certifying Murs	Practitioner: To the best of my kno	wledge, death occurred	at the time, date an	d place, and due t	o the cause(s) an	nd manne	r as stated. nth, Day, Year)
	To th withir To th		29b, Signature and time of certifier	2	29c. Lice	nse number	-/	Oct Oct	Fabe	c 192011
	1-				T 5141	J / 10 3	/	1		111011
	1081		30. Name and address of person who	completed cause of death (Item 23a)	(Type, Print)	50.20	DE NO	e GA	LB,	MIDIZ MALIOL
	الشنوي	toto	31. Date filed (Month, Day, Year)	32. Registrar's Signature	23 1	A1 100		,		}′
	Regi	itate strar	0.000.0.1	2011 Reserva A.	parker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JAMES ROGER SIMMONS OCTOBER 2011 11:06 P™ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Days Hours Months Day, Yea 217-40-8303 **Director** 1942 Maryland 69 July Usual Residence of Decedent show ms 23a or 28a-f shov must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2409 Taylor Brook Lane 21085 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: "natural" 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Senior Program Analyst other t Data Processing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ဂ James Underwood Simmons Margaret Catherine Miller 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is 1 any injury or other traumonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Simmons / Spouse 2409 Taylor Brook Lane, Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp 10-19-2011 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) McComas Funeral Home, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licens 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final magnetic Discussociation 30 min Physician/ Electro Medical resulting in death) Due to (or as a consequence of): **Examiner** 5 years Dicase PIDNOTE Arters Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of, and -tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical the attending 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes mellites - Trepe 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate, 2 1 No 2 🖪 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or A ending Phys within 24 hours after eath. To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

SIMMONE, JAIMES R NECOFOOG27 1541

Division of Vital Records, P.O. Box 68760

3altimore, Maryland 21215-0036

Registrar DHMH 17 Rev 7/2009

State

29a. Certifier (Check

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29b. Signature and title of certifier

S. Ragaraj. mp

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
S. Rose pore, mo, 208-C, Pleamtree Ro, Belosir,

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D 0053720

29d. Date signed (Month, Day, Year)

10(18/201)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 5,8 per fh 920 10-27-11 vt State of Maryland Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 430 AM O MANSKI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CANTON HARBOR CARE **FUTURE** 9. Birthplace (State or Foreign Year If Under: Security Number 7. Age (In yrs. last birthday) 86 Yrs. 1 M 2 F **Funeral** Months Days Hours MARTEAND Director 217-18-3472 10d. Inside City Limits 10a State 10b. Count 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examinar must be notified at 1 □ Yes 2 □ No Director MD. BALTIMORE CITY 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ŏ 21224 U.S.A. 1302 BONSAL STREET 'natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. WHITE Specify: If Yes, Give Year or Dates: þ 3 → Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) is marked other than OWN HOME HOME MAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental F Be CATHERINE PIEKARSKA FRANK ZARANSKI ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) s 1 and 2 of Health a item 27 is 4707 WINKSLEY COURT ELLICOTT CITY, MD 21043 JOSEPH KOSTKOWSKI-NEPHEW OCTOBER 20c. Location - City or Town, State permit. Pages 1 a
Department of He.
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 25,2011 BALTIMORE, MARYLAND HOLY ROSARY CEM. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityKACZOROWSKI FUNERAL HOME, PA 21. Signature of Funeral Service Licensee M00933 1201 DUNDALK AVENUE BALTIMORE, MD.21222 23a. Part 1. Enter the disealle, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ື່ຖysician DIGUI resulting in death) Medical Due to (or as a or sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-trai Due to (or as a consequence of): Box 68760. the attending physician the death certificate be Physician/Medical the as IF FEMALE: nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year 01 Day 5 Other (specify) P.0. detached 9 Unknown s been signed by t should be detach Pari-H: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy has certificate 1 ☐ Yes 2 XNo 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be ´2∰No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes ပ this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? P Hospital or Attending P 24 hours after death. Funeral Director: After t Certification: After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 10/19/11 0069441 N 30 Name and address of who completed cause of death (Item 23a) (Type, Print) Dadras 1300 S. Ellwood Avenue 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

OCT 2 1 2011

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			For State Registrar	State of N	/larylan		artment of H tificate of L		and Me		giene Reg. No.2		33573
	Physicia Medic		1. Decedent's Name (First, Middle PAUL D. The							2. Date of Dea		20 Year	3. Time of Death 5:11 A.M
	Examin		4a. Facility Name (if not institution CHARLOTTE HAI	, 0			4b. City, Town, or CHARLOT					ty of Death	Y'S CO.
	Funeral Director		5. Social Security Number 215-16-7063	6. Sex 1 M 2 G F	Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours		8. Date of Birt 6/14/7	th 1920	9. Birthp	place (State or Foreign L'AND
	land show dat	tor	Usual Residence of Decedent 10a. State 10b. County	,	10c. City	y, Town or Loc	cation					1	0d. Inside City Limits
	the Mary or 28a-f e notifie	Director	MD BALT 10e. Street and Number	IMORE		SPARKS	10f. Zip Code				10g. Citizen o	f What Cour	1 Yes 2 No
	ath with ms 23a must b	Funeral	15920 YORK ROA	AD 12. Was Deceden	t Ever in II 9	S 112 V	211		gin? /Sneci	fy Ves or No-		USA ace - Americ	- Indian
39	should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural" or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	۵	1 Never Married 2 Ma 3 Widowed 4 Divorce	Armed Forces	? □ No		Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🛣 No			ican, etc.)		ack, White,	
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Maryland 21215-0036	uld be filed Mental Hyg narked oth latic event,	To B	17. Father's Name (First, Middle, PAUL THOMAS	Last)					er's Name (MA BA		Maiden Surnai	ne)	
	27 E 27		19a. Informant's Name/Relations DEBORAH THOMAS			1	g Address (Street a				r, City or Town, 2 115 2	State, Zip (Code)
Baltimore,	Page 1 and 3 πent of Healt ant: If item 2 ury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 ☐ Removal from Stat	te GAR	Place of Disposemetery, creme DENS O	sition <i>(Name of</i> natory or other plac FFAITH(EM.	10/2	ate 2/2011	20c. Location PARK\	n - City or To	
Baltı	permit. Page 1 Department of Important: If i any injury or o		21. Signature of Funeral Service	Lic Insee MO1139	150		Name and Addres				ON FUNE		OME, P.A. 286
	De executed Medical sician and purial-transit purial-transit	ical Examiner	234 Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	a. Cara	s a conseque	gence of):	r the mode of dyin	g, such as	cardiac or	respiratory an	rest,		Approximate Interval Between Onset and Death
Box 6876(IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknown	n 2 ☐ Feta at time of c	ıl death 3 🗌	Ectopic pregnanc	;y				Date of delive	ery Day Year
a)	e lav e has ge 2	Completed by Physician/Med	Part II. Other significant conditions and the significant conditions are significant conditions.				nderlying cause giv	ven in Part	1.	1 24a. Was	Yes 2 No	3 Prob	bably 4 Unknown psy findings available mpletion of cause of
/ital	rsician: The Taw Is certificate has the Isrector, page 2 s		25. Was case referred t edical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ationt 2	ER/Outpatien	Othe	er:	th (Check o	only one)	dence 6 🗆 Of		
n of	iding Phy th. After this funeral c		27. Manne of Death 1 Natural 5 Pendi 2 Accident Invest	28a. Date of in	jury	28b. Time of injury	28c. Injury work	/ at	28		now injury occu)
Division of	il or Atter after dea Director d in by the	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of Ir	njury - At ho etc. (Specify	me, farm, stre	eet, factory, office		28	8f. Location (5 City or Tow		ber or Rural	Route Number,
	to the Propriat or Attending Prysician: In within 24 hours after death. To the Funeral Director: After this certificate completed filled in by the funeral director, pa	Medical	(Check 2 Dedical	g Physician: To the best of Examiner: On the basis of g Nurse Practioner: To the	examination	and/or invest	igation, in my opinio	on, death od	ccurred at th	ne time, date a	ind place, and c	lue to the car	use(s) and manner stated.
	vithir To th comp	2	29b. Signature and title of certifie			7		number	78		29d. Date sign		
•			30. Name and address of person		,		-	<u>/_e</u>	<u>O</u>	1	1411	///	
	Stat Registra	e	Mariesa Kinch 31. Date filed (Month Pay Year) OCT 21	29449 Char1 2011 (2. Regis		ure fau		<u>iotte</u>	Hall	, MD	20622_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per doc g920 10-31=11 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day KA M Mari **Physician** Tinkler 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Ye Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) 935 1 M 2 LE 215-32-712 Director 6 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No Director tomos 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 2120 Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene.
is marked other than "natural", or ite 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 🗌 Yes Specify Blace à Specify: 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) tomema 18. Mother's Name (First, Middle, Maiden Surname) other traumatic event, 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic evoluce. Ward NWO IMA ည rown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ashland 21205 to Mole lamme 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 2 Cremation 3 Removal from State Balti more 10/21/2011 5 Other (Specify) 5 of Funeral Service 2. Name and Address of Facility HOX Ne Heights Balto. MD 21207 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final ocard Physician disease or condition resulting in death) /Medical Due to (or as a onsequence of) Examiner Sequentially list conditions, if any, leading to increase Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Durate for as a consequence of the death certificate be executed attending physician and I for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 🗌 Yes 2 No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗌 Inpatient Other: 4 Nursing Home 5 Residence 1 Yes 2 □ No 2 R/Outpatient 3 DOA 6 Other (Specify) မ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation Injury or Attending 1 🗌 Yes 2 | No death. 2 Accident after death 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (check only Medical one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 10-15-11 30. Name and appress of person who o cause of death (Item 23a) (Type, Print) Øshua 600 North Wolfe St, Baltimore, MD, 21287 ·vb(t O 31. Date filed (Month, Day, Year) 32. Registrer s Signa State OCT 2 1 2011 Registrar

DHMH 17 Rev 1/2001

11-07716 Vernon Earl Tayl	or	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jr. State of Maryland / Department of Health and Mental Hygiene	
Vernon Lan Tayı		1- For State Certificate of Death Certificate of Death Reg. No. 2011	3357
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Vest	
\bigcap		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
Funeral	4	2720 East Preston St, 2nd floor Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (Security Number Programme)	State or
Director	1	217-62-6102 1 VM 2 F 55 Yrs. Months Days Hours Min. Jan 16, 1956 Foreign Country) Usual Residence of Decedent	MD
ow any	Ī	10a. State 10b. County 10c. City, Town or Location 10d. Inst	ide City Limits
he Maryland or 28a-f show : ified at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
with the	ralDi	2 12 13 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American India	n, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Midical Examiner must be notified at once.	/ Funeral		K
hours at natural	ted by	or Dates:	
:1215-0036 Id be filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Transporta	tion
115-0 filed w al Hygie ced othe	Be Co		
AD 212 2 should be h and Ment 27 is mark Imatic ever	입	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod	e)
e, MC and 2 s Health an item 27		Van Sturtevant 1502 MCCabo Ave, Baltimore, M. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, St	<u>) </u>
imore Pages I nent of H ant: If		1 Description 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify: Ling Memorial 10/21/2011 Baltimore,	M
Balti Permit Departi Import		21. Sign fe of Funeral Service Using 22. Name and Address of Facility Howell Funeral How well Funeral	Horne
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approx	ximate Interval
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Cardiovascular Disease Due to (or as a consequence of):	Death
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	xaminer	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated C.	
executed an and al - transit	Ш	d	
7 H	edica	UNPENDED AMENDED IF FFMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
Ox 68760, ant certificate be exc attending physician for use as the burial -	ian/M	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Pregnant at time of 5 Other (Specific)	Year
Box 68760, a death certificate be the attending physicate be death of the attending physicate for use as the bu	Physician/Medical	1 Yes 2 No 9 Unknown 5 Other (Specify) 4 Pregnant at time or 5 Other (Specify)	
ords, P.O. Box wrequires that the deatl sheen signed by the att should be detached for	ģ	Asthma 1 Yes 2 No 3 Probably 4	
rds, require been sig	Completed	24a. Was an 24b. Were autopsy fin autopsy prior to completio	
Division of Vital Records, tal or Attending Physician: The law requinrs after death. Tal Director: After this certificate has been sited in by the funeral director, page 2 should be	Somp	performed? death? 1	2 No
Vital Rec ysician: The I his certificate I director, page	Be	25. Was case referred to medical 26. Place of Death (Check only one)	
of Vit ing Physic After this commeral dire	n: To	7 Marcon of Date of Latina 2004 Time of Latina 2004 Deposition how injury operated	
ivision of or Attending Phatter death. Director: After to him by the funeral	catio	Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route	Number City
Divipital or ours after eral Direction	Certification:	3 Suicide 6 Could not be determined (Specify) Suicide 6 Could not be determined (Specify)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burin	Medical C		s)
To with To com	Mec		
		O.C.M.E. October 15, 2011	
λ		30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	
DHMH 17 Rev 1/20		Line D. Survey	

DHMH 17 Rev 1/2001 OCME 2006

OCME

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20

			1 - State Registrar State of Maryland / Depart	tment of Health and N ificate of Death	nental Hygie Reg.	- ZUII 335/b
H	Physicia	ın/	Decedent's Name (First, Middle, Last) Melba Augusta Totty		2. Date of Death	Day Year 20, 2011 2:00 AM
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	OGEOD	4c. County of Death
-	Funeral		13 K Brook Farm Ct. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Perry H If Under 1 Year If Under 24 Hrs.	all 8. Date of Birth	Baltimore 9. Birthplace (State or Foreign
Ē	Director			Months Days Hours Min.	Month, Day Yes,	1925 Maryland
	/land f show ed at	tor		tion		10d. Inside City Limits
	or 28a-	Direc	MD Baltimore Perry Ha 10e. Street and Number	111 10f. Zip Code	100	1 ☐ Yes 2 No Citizen of What Country?
	s 23a o	Funeral Director	13 K Brook Farm Ct.	21128	109.	United States
36	a filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 Ves 2 No	s Decedent of Hispanic Origin? (Spe 'es, specify Cuban, Mexican, Puerto Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
2-00	2 hours "natur edical E	Completed	15. Decedent's Education 16a. Deceder (Give kin	nt's Usual Occupation	ina 16t	o. Kind of Business/Industry
21215-0036	vithin 7, giene.		Elementary/Secondary (0-12) College (1-4 or 5+) Iffe. DO Admi	NOT use retired) nistrative Assis		Finance
/land	should be filed within 7: h and Mental Hygiene. 7 is marked other than traumatic event, the Me	To Be	17. Father's Name (First, Middle, Last) William Spielmann		e (First, Middle, Maid Padgett	(en Surname)
, Man	2 1		1 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1-	Address (Street and Number or Rura Woodfall Rd. No		
Baltimore, Maryland	permit. Page 1 and Department of Hea Important: If item any injury or other once.		Bullat 2 2 Grennation o E hemoval nom otate	ion (Name of tory or other place) ke Crematory	Öct 21, ²⁰⁰ 2011	c. Location - City or Town, State Beltsville, Maryland
Balt	permit Depart Import any inj once.			Name and Address of Facility Cremation and Fune 8717 Green Pasture		atives wson Maryland 21286
Ī			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.			Approximate Interval Between
بالمعتار	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequency of):	Monecytic 1.	eukem	Onset and Death
	Examiner	r.	Sequentially list conditions, b.	111		
	ited	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	icate be executed physician and is the burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence of):			
3760	ficate b g physic as the b	Nedical	d			
Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/M		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
P.O.	that the ned by e detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the unc	erlying cause given in Part I.	3	co use contribute to the cause of death?
rds,	equires een sig nould b				1 🗆 Yes	2 No 3 Probably 4 Unknown
eco	he law r te has b age 2 sl	Completed			24a. Was an autopsy performed	
talF	sician: The law is certificate has t	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check	1 Yes 2 2	No 1 ☐ Yes 2 ☐ No
ot VI	g Physi er this c	e: To	1 Pes 2 Lurko 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of injury 28b. Time of	28c. Injury at	me 5 Residence 28d. Describe how in	e 6 Other (Specify)
lon	tending leath. tor: Afte the fun	Certificate:	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation 3 Suicide 6 Could not be	work? M 1 ☐ Yes 2 ☐ No		
Division of Vital Records, P.	al or At s after c l Direct		4 Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, late)
	To the Pospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification post open place in by the funeral director, completely filled in by the funeral director,	Medical	29a. Certifier (Check (Check only one) (Check only one) (Check only one) (Check only one) (Certifying Nurse Practitioner: To the best of my knowledge, death occ	ation, in my opinion, death occurred at	the time, date and pl	ace, and due to the cause(s) and manner stated.
	with with		29b. Signature and title of certifier K. D. Schlenden - Physician	29c. License number		Date signed (Month, Day, Year) 10 -20 - 2011
	178		30. Name and address of person who completed cause of death (Item 23a) (Type, Print WEV IN SCHOOL MID 9114 Philat	Telphia RD, Su	ite 300	10-20-2011 BAGO MD 21237
	Stat Registra	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ake		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ANDA /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Oak Crest Parkville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 💢 F Director 212-09-6926 91 1920 Maryland Jan. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Modical Examination to natified at 1 ☐ Yes 2 X No Directo Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blvd. Apt. 3201 2 should be filed within 72 hours after death v n and Mental Hygiene. is marked other than "natural", or items 23s Funeral 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No þ Specify. Specify: 3X Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Andrew Czyz <u>Victoria</u> <u>Nagrabski</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health ar item 27 is 9036 Sunni Shade Court Perry Hall, Maryland pate 20c. Location - City or Town, State Leo Umerley, Jr. 20b. Place of Disposition (Name of Demotery, crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition permit. Pages 1 Department of I Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5XiOther (\$Protection to the contract of the contr al Gardens 10-22-2011 Timonium Maryland
22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Si noture de Poeral Servide Licensee 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Vaginal cance Munth /Medical (or as a consequence of): Examiner Sequentially list conditions, in the limit of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) P.0. 1 □Yes 2 □No the 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has e 2 s 24a. Was an autopsy performed? Yes 2 No r this certificate has 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Statement 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ctor; After thi 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I 29b. Signature and title of certif 29c. License number 29d. Date signed (Month. Day. Year) D73112 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 Walthe Blud Porkalle JUL f+00 -and min

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type of Printin Black Indelible Ink. of France All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 33578 Reg. No.Z U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O Vear **Physician** Carlos Figueroa Vidal /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Good Samaritan Hospital 6. Sex 1 M M 2 ☐ F Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) **Funeral** 03/09/1942 Director Lima, Peru 69 219-79-5163 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, its Medical Examer rust by notified at 1 Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21214 Peru 3043 Pinwood Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐Yes 2X No Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, If Ne Elementary/Secondary (0-12) College (1-4or 5+) Banking Industry Industrial Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosalina Vidal ပ Adan Figueroa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (wife) 3043 Pinewood Avenue - Baltimore, Maryland 21214 <u>Carola Ubillus</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) St. Joseph Ch. Cem. 10/24/2011 Baltimore, Maryland re of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 5 Other (specify) P.0. the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a Was an autopsy performed Yes this certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Wes 2XER/Outpatient 3 □ DOA 1 Inpatient Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending 1 ☐Yes 2 ☐No n 24 hours after death. • Funeral Director: ₱ bletely filled in by the fu death. investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗺 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiper: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 0 29b. Signature and title of certific 00016948

DHMH 17 Rev 1/2001

State Registrar 5601 Loch Raven Boulevard, Baltimore Maryland 21239

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

tock, MO

dress of person who

31. Date filed (Month, Day, Year)

		-	For State Registrar		State of M	arylan		artme <i>rtifica</i> i			nd Mental H	ygien Reg. N	2111	1	33579
	Physicia		1. Decedent's Name	e (First, Middle, La:	st) WHITTAKE	ER					2. Date of D Month			Year	3. Time of Death
	Medic Examin			_	street and number)	Tal		4b. City		Location of D	Death		c. County o	f Death	101 €
	Funeral Director		5. Social Security N 220 50	lumber 6. S			ast birthday) Yrs.	If Unde Months	er 1 Year	If Under 24		irth Jay, Year) 4, /ear)		9. Birthp	lace (State or Foreign LAND
	yland f show ed at	ctor	Usual Residence of 10a. State	10b. County	(ODE		ty, Town or Lo							11	0d. Inside City Limits
å	h the Mar 3a or 28a- be notifi	Funeral Director	MD 10e. Street and Nur			R	OSEDA		ip Code	237		10g. C	Citizen of WI	hat Coun	
9500 7 pro	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	۵	11. Marital Status	PRING AV	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	Ever in U.S			edent of Hi ecify Cuba		? (Specify Yes or No Puerto Rican, etc.))-	14. Race		etc.
Harold 21215-0036	vithin 72 hour jiene. er than "natu the Medical	Completed	(Spe Elementary/Sec 12	15. Decedent's E ecify only highest gr conday (0-12)		5+)	(Give life. L	dent's Usu kind of wo DO NOT us LTOR	ork done d se retired)	ation during most of	f working		Kind of Bus		
Ather Maryland	d be filed v dental Hyg irked othe tic event,	To Be	17. Father's Name (TAKER						s Name <i>(First, Middl</i> B ERTA		n Sumame) LISON	1	
# HA	d 2 should alth and N 1 27 is ma er trauma		19a. Informant's Na	ame/Relationship (7	ype, Print) TAKER/WI	FE					or Rural Route Numi				
WH;∏ Baltimore,	Page 1 and of Her of Her or If item		20a. Method of Disp 1 Durial 2 4 Donation		Removal from State		Place of Disponentery, cre	matory or	other plac	e) 1 (Date 0/20/11	1	Location - C	-	
≪ Balti	permit. Departn Importa any inju		21. Signature of Fu				2	2. Name a	nd Addres	ss of Facility (CVACH/RC AVE BAL	SED.	ALE I	FUNE MD	ERAL HOME 21237
. see	hysician/		23a. Part 1. Enter t shock, or hea Immediate Cause disease or condition	art failure. List only o (Final	plications that caused one cause on each line	e.			de of dying	g, such as ca	rdiac or respiratory	arrest,			Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	ſ	a. Bue to (or as	a consequ	uence of):		TOI	na		λ	20	100	3
. 93	uted d ansit	aminer	Sequentially list containly leading to he cause. Enter Unde Cause (Disease or that initiated event	erlying	Due to (or as	a cor seqi				5	Sprove		D	K	×
8 Ma	cate be executed physician and the burial-transit	edical Examiner	resulting in death)	Last	Due to (or as	a conseq	uence of):					Mys	Wirk		
Division of Vital Records, P.O. Box 68760		Ž	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	aldeath 3	☐ Ectopic☐ Other (s		y	12	v.	23d. Date Mon		ery Day Year
s, P.O.	ires that th signed by Id be detac	þ	Part II. Other signit	ficant conditions	ontributing to death b	out not res	sulting in the	underlying	cause giv	en in Part I.					ne cause of death?
Record	The law requate has beer bage 2 shou	Completed									pe	s an topsy formed?	pr de	ere autorior to coreath?	psy findings available mpletion of cause of
Vital F	ysician: 1 s certifica director, p		25. Was case referrence examine? 1 Yes 2	red to medical	Hospital:	ient 2 🗆	ER/Outpatie	ent 3 🗆 🗆	Otho	2r.	(Check only one)			(Specify)
ion of	tending Phy death. tor: After this the funeral o	Certificate: T	27. Manner of Deat 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide	th 5 Pending Investigatio 6 Could not be	28a. Date of inju (Month, Da	iry y, Year) 2011	28b. Time of injury 7 4 5	of AM	28c. Injury work 1 \square	/ at	28d. Describe	how inju	ury occurred	Por	Т
Divis	vital or At urs after or ral Directilled in by		4 Homicide	determined	building, et	S P	2ins	AU-	e -1	Home	City or T Rosec	la l	te) M	ol Z	Route Number,
	the Host thin 24 ho the Fune mpleted fi	Medical	(Check 2 only one) 3	Medical Exam	rsician: To the best of niner: On the basis of e se Practioner: To the	examinatio	n and/or inve	stigation, ir death occ	n my opinic urred at the	on, death occu e time, date ar	irred at the time, dat	e and place the cause	ce, and due e(s) and mar	to the cai	use(s) and manner stated ated.
	5		29b. Signature and	A, MI)			29	c. License	s number	00		Oate signed		
_	6		ORBLE	essing Y	completed cause of c	4000	FARA		n S	Qual	EDR	Ba	Ltou	10	21237
	Stat		31. Date filed (Nont	th, Day, Year)	32. Registr	ar's Signa	Rure and								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ october 20, 2011 Edith Martha Wheeler 7:20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7220 Golden Ring Road Baltimore Essex 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days 1 🗆 M 2 🔀 F 85 10775/1926 Maryland **Director** 219-22-9831 2 should be filed within 72 hours after death with the Maryland the and Mental hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7220 Golden Ring Road 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary / Treasurer Marine Repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Betz Rose Poetsch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, item 27 J. Stanley Wheeler (Husband) 7220 Golden Ring Road, Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o zion U.C.C. Church 1 X Burial 2 Cremation 3 Removal from State 10/22/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Renal Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any course Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death in the past 12 months? Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 ☐ Yes 2 ☐ No performed? Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 Residence 6 \square Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

016801

Mª (7 WIRE MD 9103 Franklin Square Dr. Balto MD 2123.7

William P. M. Accese

31. Date filed (Month, Day, Year) OCT 2 1 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

21 OCT ZON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 10 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City Town, or Location of Death 4c. County of Death HOLANGI Alli MOSE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 F 86 Yrs. Hours Month, Day, Y Country) Months Min 214-40-187 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County any injury or other traumatic event, the Medic J Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🙎 Yeş 2 🗆 No 10 timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21218 items 2 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. "natural", or δ 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give Year or Dates. 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) onsignmen DIOV Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Kanda Ustown 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -OHES 21. Signature Uneral Service Li (D 21207 nts 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician With disease or condition resulting in death) Medical Due t (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month Month Day Year Pregnant at time of death signed by the at Id be detached fo P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy death? 1 🗌 Yes 2 No Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work' 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Day, Year, mpleted cause of death (Item 23a) (Type, Print) -DARN4A 8813 W MULLANG filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARIE A. WOLF 3:18PM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPITAL BALTIMORE 1 mp BALTIMORE CITY 000 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours **Director** 215-01-9566 1 □ M 💆 🖰 F 93 May 11,1918 Maryland · 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore County Maryland 1 Yes 2 X No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 109 Elinor Avenue 21236 USA "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Completed by Black, White, etc. 1 Never Married 2 Married 1 Yes X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White **X** Widowed 4 □ Divorced Health and Mental Hygiene.
em 27 is marked other than "natur ther traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 6th grade Homemaker Homemaking-Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lawrence Thanner Sophie Schoenhoff 19a. Informant's Name/Relationship (Type, Print) David Wolf (Son) 8918 Hinton Ave. Baltimore, Md. 21219 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If it any injury or o once. Department of XXX Burial 2 Cremation 3 Removal from State Gardens of Faith Baltimore, Md. 4 Donation 5 Other (Specify) 10-24-2011 22. Name and Address of Facility Lassahn Funeral Home 21. Signature of Funeral Service Licensee 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ EPTIC SHOCK disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending Id be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Year Day 1 ☐ Yes 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by LYMPHOCYTIC LEYKEMIA cate has been signated by page 2 should b 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes FIBRIKLATION AT PIAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The 124 hours after death.
 Funeral Director: After this certificate h performe Yes 🔑 filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 은 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 2011 BALTIMORE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 LOCH RAVEN BLUD, mo 21239 SEHG AL SAMEEP 560 Date filed (Month, Day, Year 32. Registrar's Signature State OCT 2 1 2011 Jacks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33583 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1321 tinna 201 octobu Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Butimore MMMS Birthplace (State or Foreign Country)
 NC If Under 24 Hrs. 8. Date of Birth If Under **Funeral** Social Security Number last birthday Months 1 - M 2 X F 1472571974 unkn. Yrs Director Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene. Hart; If item 27 is marked other than "natural", or items 23a or 28a-f sho inty or or other traunatic event, the Medical Examiner must be notified at inty or other traunatic event, the Medical Examiner must be notified at 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Baltimore MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? unkn. unkn USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) disabled n/a Be 17. Father's Name (First, Middle, Last) Glenn Tyrone 18. Mother's Name (First, Middle Maiden Surname)
Patricia Walker Thompson ပ 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1329 Meridene Drive, Baltimore, MD 21239 Patricia Walker/Mother Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place Atlantic Crematory 10/23/2011 Glen Burnie, MD 4 Donation 5 Other (Specify) peral Service Licensee Orota Marshall 22. Name and Address of Facility Remarking Servimbs 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ *ก*กานในนั้น disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a conse Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-trar Due to (or as a consequence 🛫 resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 GERTIFICATION NO IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 XYes Hospital 2 No မြ 1 KInpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide injury 5 Pending 30 PM 2 **X** No 10,201 1 Yes Investigation the. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be within 24 hours after de **To the Funeral Directo** completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 10me 405 S. Bentalou 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signate

Registrar
DHMH 17 Rev 7/2009

State

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name, (First, Middle, Last) 2. Date of Death Day Month Year Physician/ Walts 50 A olanda 19 Medical 4c. County of Death not institution, give street and number, **Examiner** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) last birthday) **Funeral** Months Hours Director 1 M 2 XE 28a-f show 10d. Inside City Limits City, Town or Location items 23a or 28a-f sho her must be notified at 10a. State 10b. County 10c death with the Maryland Director 1 Des 2 No 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Examiner d For Black, White, etc 0 1 Never Married 2 Married þ 2 No Maryland 21215-0036 Yes 1 Yes 2 No If Yes, Give Year or Dates Specify "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry h and Mental Hygiene.
7 is marked other than "r College (1-4 or 5+) Be Father's Name (First, Middle, Last) 2 19b. Mailing Address (Street and Nu permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau once. MI Baltimore, 20b. Place of Disposition (Name of 1 Rurial remation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 21212 MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Luna Cancer . Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō The law requires that the death Month Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown be detached the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Yes 2 No Completed should Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy has 1 Yes 2 No Director: After this certificate Yes 2 To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this madding. director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 4 Nursing Home 5 Residence 6 Other (Specify) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident Investigation filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier (MS/Cy MPAGMUNI) 29c. License number 29d. Date signed (Month, Day, Year) DDD57465 10/20/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21209 5203 2835 Smin Rajapa Kse, M.D AV 32. Registrar's Signature State acks Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 17, 2011 Caleb Winslow Jr. 2:05 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 128 West Ring Factory Road Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 □ F (Month, Day, Year) ar. 3, 1918 Country)
Maryland Director 217-26-6711 93 Usual Residence of Decedent ms 23a or 28a-f show must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland | Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 128 West Ring Factory Road 21014 USA "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 X Yes 2 □ No 1 Never Married 2 Married Black White etc. Completed by Maryland 21215-0036 1 Yes 2 No Specify. 3 Divorced If Yes, Give Specify. Year or Dates White event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 Pof Health and Mental Hygiene. I item 27 is marked other than "nother traumatic event, the Medi Elementary/Seconday (0-12) College (1-4 or 5+) Photographic Specialist U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Caleb (nmn) Winslow Sr. Lena Rebecca Garey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21014 Ann D. Winslow / Wife 128 West Ring Factory Road, Apt. 1255, Bel Air, MD t: If item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 10-19-2011 Towson, Maryland 21. Signature of Fungral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicianz 50 W disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Thernew lumbor Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery s been signed by the atter should be detached for t in the past 12 months? Month Day Year Yes 2 No 1 L Yes 2 L 9 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performed? 2 No 1 🗌 Yes Yes Be (funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D3555 OCI-PULLY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21014 615 W.M

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

OCT

21

32. Registrar's Signatur

615 W. MacPhail Road.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Jane Anne Zinda October 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SANT 1 5. Social Security Number BALT more Agnes Hos OLTAI Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. ge (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 1 F 87 Director 1924 Pennsylvania Jan 22, 195-16-0479 Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 10a. State 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö items 23a United States 2018 Oakland Rd 21220 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 0 1 □Yes 2 No Specify: þ 3 ☐ Widowed 4 Ď Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Lever Brothers 12 Product Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Abraham Mike Esther Mulkey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau Colleen Felts /Niece 2018 Oakland Rd. Essex, MD 21220 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct 21 Beltsville, Maryland Chesapeake Crematory 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Alternatives Metocca 8717 Green Pastures Drive Towson Maryland 21286 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** unknown Due to (or a construence of): /Medical Examiner robable INKNOWN Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to lor as a consequence of The law requires that the death certificate be executed Asystole Inknown physician a s the burial-t Division of Vital Records, P.O. Box 68760 Physician/Medical Ardiopulmonar attending philosophia to the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Live birth 2 Fetal death
Pregnant at time of death in the past 12 months? Month Day Year 5 ☐ Other (specify) ned by the a 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 2 No page certificate 1 ☐ Yes 2 🗷 Ño rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA uneral dir Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Hospital or Attending 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No iours after death.

neral Director: A
filled in by the fu death. investigation 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 South CATON AVE HUSPITAL

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

32 Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director, After this certificate I completed filled in by the funeral director, page	Medical	(Check 2	Certifying Medical I	xaminer: On	the basis of	examinatio	n and/or inve	stigation, in	n my opinio	on, death od	curred a	t the time, date	e and place	e, and d	ue to the	cause(s) and manner sta	ted.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Kalyani Acharya October 9, 2011 6:55 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Numbe If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Min. 1 🗆 M 2 🕱 F Director (Unav 86 November 16,1924 | Sherpur, Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director West Bengal 1 X Yes 2 No Kolkata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23 East Point, Sonamoni, Flat All 700078 India Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes Give Specify: Indian 3 Midowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Chandra Kumar Bhattacharyya Subasini Choudhury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Malay Acharya / Son 3517 Turner Lane, Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 🗵 Cremation 3 D Removal from State 10/10/2011 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Part 1. Enter the dishase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Cardiac Arrest Medical resulting in death) Due to (or as a consequence of): Examiner Intracerebral Bleeding Non Traumatic Due to Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence on physician and the burial-transit Subarachnoid Hemorrhage Non Traumatic Due to Hypertension that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 \square Yes 2 \square No 3 \square Probably 4 \boxtimes Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Other: ည 1 🗆 Yes 2 🖾 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation 24 hours after deat Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) 00065182 Heram emy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sima Nourani Zenuz, M.D., 8600 Old Georgetown Road, Bethesda, MD 20814

Registrar

DHMH 17 Rev 7/2009

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AL

32. Regist ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Mary		irtment of F <i>tificate of D</i>	lealth and Me Death		ene a No 2 N I I	33580
	Physicia	ın/ [°]	Decedent's Name (First, Middle, Last) Mathew Karl Amberg			2	. Date of Death	Day Year	3. Time of Death 10:45 P.M
may	Medic Examin	al	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	october	4c. County of Dea	ıth
-et	Famount		6E Hillside Road 5. Social Security Number 6. Sex 7. Age (Ir	n yrs. last birthday)	Greenbe		. Date of Birth	Prince Ge	eorges rthplace (State or Foreign
	Funeral Director		121-09-2982 1 ₺ M 2 □ F	93 Yrs.	Months Days		(Month, Day, You	,1918 Net	w York
	land f show d at	tor		Oc. City, Town or Loc Greenbelt				-	10d. Inside City Limits
	he Mary or 28a-i notifie	Director	10e. Street and Number	Greenberd	10f. Zip Code		10	g. Citizen of What C	1 XYes 2 No
	h with the rs 23a on nust be	Funeral	6E Hillside Road		20770		Ţ	United Sta	
21215-0036	72 hours after death with the Maryland n"natural", or items 23a or 28a-f show fedical Examiner must be notified at	Completed by Fu	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	If	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🛣 No	spanic Origin? (Specifin, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.
215-(n 72 hou t. an "nat Medica	mple	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k	ent's Usual Occupa ind of work done d NOT use retired)	ation luring most of working	10	6b. Kind of Business	s Industry
d 21	ed within Hygiene. other thar ent, the M	Be Co	17. Father's Name (First, Middle, Last)	Jour	malist	18. Mother's Name (F	First Middle Ma	Media	
ylan	should be filed n and Mental Hy 7 is marked oth raumatic event	2	Maurice Amberg			,	shitz	idan damamay	
	0 ± 0 +		19a. Informant's Name/Relationship (Type, Print) Ruth Rebecca Amberg/Daughter			and Number or Rural R ., Arlingto			ip Code)
Baltimore,	permit. Page 1 and Department of Heal Important: If item 3 any injury or other once.		1 🗌 Burial 2 🗌 Cremation 3 🔲 Removal from State	20b. Place of Dispos Geo Wash Medical C	enter	2011	5 _{Wa}	oc. Location - City o ashington	, D.C.
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee				rtuary Se , MD 2070	rvices, P.A.	
	medical Examiner Department of the prival classic many the prival classic many the prival classic many classi	al Examiner	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause or peach line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, hading to him additionable cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a condition or as a co	onsequence of):	of Catu	g, such as cardiac or re	espiratory arrest		Approximate Interval Between Onset and Death
D. Box 68760	Ine law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/Medical	1	Fetal death 3 me of death 5	Other (specify)			23d. Date of d	elivery Day Year
ls, P.O.	uires that n signed uld be del	by	Part II. Other significant conditions contributing to death but r	not resulting in the u	nderlying cause giv	ren in Part I.			to the cause of death? Probably 4 Unknown
Division of Vital Records,	sician: The law req certificate has bee irector, page 2 shoi	Completed	OC Management Assembled		-		24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
Vita	nysiciar nis certii directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatien	Otho	ace of Death <i>(Check or</i> er: 4		ce 6 Other (Spe	ecify)
on of	In the hospital or Attending Physician: To the Funeral Director. After this certifica completed filled in by the funeral director, is	Certificate:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation	28b. Time of injury	28c. Injury work M 1	yat ? Yes 2 □ No	d. Describe how	injury occurred	
Divisi	al or Atte s after de l Directo d in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (S	- At home, farm, stre Specify)	et, factory, office	28	f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	e Hospit 24 hour e Funera pleted fille	Medical	29a. Certifier (Check chick conly one) 1 Certifying Physician: To the best of my dedical Examiner: On the basis of examonly one) 3 Certifying Nurse Practioner: To the best of my dedical Examiner: To the best	nin <i>a</i> tion and/or investi	gation, in my opinic	n, death occurred at the	e time, date and	place, and due to the	e cause(s) and manner stated.
	Noth Toth Comp	-	29b Signature and title of certified		29c. License		290	d. Date signed (Mon	th, Day, Year)
			30. Name and address of person who completed cause of death Ivan Zama, M.D.	h (Item 23a) (Type, P	rint) 9200	Basil Cour	t Suite		-
	Stat Registra		31. Date filed (Month, Day, Year) / 32. Registrar's	Signature	татуо	, MD 20774			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JOSEPH BRUNER FRANCIS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western MD Regional Medical Center Cumberland g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number , Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours 04/16/1920 1 ★ M 2 □ F 216-18-1798 91 Pennsylvania Director Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director the Medical Examiner must be notified 1 🗆 Yes 2X No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 14511 Baltimore Pike, N.E. 21502 items ? 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. þ 1 Never Married 2 X Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: White 3 Widowed 4 Divorced Completed WWII Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) Allegany Ballistics should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Laboratory Maintenance Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bertha V. Oliver Calvin Perry Bruner other traumatic ge 1 and 2 should be it of Health and Mer If item 27 is marke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14511 Baltimore Pike, N.E., Cumberland, MD 21502 Doris Bruner / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If ii any injury or o 1 K Burial 2 Cremation 3 Removal from State Restlawn Meml.Gardens 10/05/2011 LaVale, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Upchurch Funeral Home, Signature of Funeral Service License 202 Greene St., Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDIAC Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending particle by the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? cate has by page 2 s within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, page 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2× No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 IDOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 🗌 No 1 Tes ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and tiţle of certifier MOORE, MP D72287 09-30-2011

Registrar

9+

Charles Moore, M.D. - 12500 Willowbrook Road, Cumberland, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Nag (First, Middle, Last) 2. Date of Death Physician/ Bethea 10/04 PM 1201 Medical Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death nextient Care Center Arundel Anne Social Security Number If Under 1 Year | If Under **Funeral** 6. Sex Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔄 Days Months Hours Min. (Month Day Year) 12/19/1969 **Director** 579-11-5915 41 Washington, DCUsual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George's Upper Marlboro 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12907 Keverton Dr. 20774 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No þ 1 Never Married 2 🔀 Married Black, White, etc. Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🙀 No Specify. 3 Divorced Completed Specify: Black Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Pharmacy Technician Private Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Bethea, Sr. Jerry Caro1 Goodwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith McAbee / Husband 12907 Keverton Dr. Upper Marlboro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 10/11/11 Brentwood, Md 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Serv rances 3401 Bladensburg Rd. Brentwood, Md 20722 23a Part 1. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure Immediate Cause (Final disease or condition Physician/ 0100 ance Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): and -transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day 1 Yes 2 y been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has blirector, page 2 s autopsy performed? 2 | No 1 Yes Within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 XNatural 5 Pending injury Accident
Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Within 2 only one) 29b. Signature and title of certifie 2 29d. Date signed (Month, Day, Year) ano 2011

Registrar

State

31. Date filed (Month, Day, Year)

2011

Detense

address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#17.PerFHPGC10-18-11cr Certificate of Death Reg. No/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER HAROLD BARRON 2011 1:14 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 13002 WEISS DRIVE PRINCE GEORGE'S BOWIE 9. Birthplace (State or Foreign . Social Security Number If Under 24 Hrs. 8 Date of Birth **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year 1 XM 2 - F Days Min JUNE 3 1943 VĬŔĠĬŊĬĄ Director 227-50-7149 68 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 XYes 2 ☐ No PRINCE GEORGE'S MD BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13002 WEISS DRIVE 20715 USA items 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 NoAIRFORCE
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. 0 1 Never Married 2X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No BLACK 3 Divorced Specify: Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the ACCOUNTANT GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental F JAMES MORFLEET NORFLEET THELMA CARTWRIGHT traumatic f Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13002 WEISS DRIVE BOWIE, MARYLAND 20715 Page 1 and 2 LAVERNE BARRON/WIFE item 2 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) of = 6 1 Burial 2 Cremation 3 Removal from State Important: I any injury o MD VETERANS CEMETERY 10/17/2011 4 ☐ Donation 5 ☐ Other (Specify) CHELTENHAM, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Signature of Fuperal Service License 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1/ Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ TERMINAL BRAIN CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of, the burial-transi HYPERLIPIDEMIA this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 XNo 3 Probably 4 Unknown DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 No Yes 2X No 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: ၉ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 X Natural 5 Pending iniury work?
1 Yes 2 🗌 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number OCTOBER 10, 2011 unil D13339 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TSUNIE CHANCHIEN, MD 8824 CUNNIGHAM DR, BERWYN HEIGHTS, MD 20740 SUITE A Date filed (Month, Day, Yea 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death September Physician/ 11:47 PM Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 4a. Facility Name (if not institution, give street and number) Adventist Park Takoma Youtgonery Washington Hospital Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace State or Foreign 7. Age (In yrs. last birthday) Funeral Months Hours Min Country) Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14 Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Be Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) eight 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 10 4 Donation 5 Other (Specify) 22. Name and Address of Facility Approximate Interval 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Rena disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the a d be detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examine? Hospital: Other: 2 No 욘 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending s after death.

I Director: Aft
d in by the fur 2 🗆 No 2 Accident
3 Suicide
4 Homicide 1 Tyes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by determined Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🛮 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. fiftying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 0067427 October 2011 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Takoma eorae 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day Physician/ Estella Thornton Brown 11:20 P M 2011 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington Health & Rehab Center Prince George's Fort Washington . Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) WV 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🕇 F Days Hours (Month, Day, Yea 577-44-6943 85 **Director** 1926 6. une Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Bowie 1X Yes 2 No Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20720 4212 Day Lily Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Private Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Lucious Thornton Martha Thornton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4212 Day Lily Drive, Bowie, MD 20720 Sandra A. White/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State Riverdale Park Crematory 10/7/2011 Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Censee 22. Name and Address of Facility Pope Funeral Homes Pope 5538 Marlboro Pike, Forestville, Ma 20746 Communs Larre 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicians Dementia Alzheimer's Type Medical resulting in death) Due to (or as a consequence of) Examiner <u>Atherosclerosis Cerebrovascular Disease</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) the 9 🗌 Unknown sate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Feeding Dysfunction 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Osteoporosis 24a. Was an autopsy performed?

1 Yes 2 No this certificate 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 2² No Other: 4 Mursing Home 5 - Residence 6 - Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Medical 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and Tille of certifier 29d. Date signed (Month, Day, Year) D42955 00 11

State Registrar 30. Name and address of person

Edgar Potter, 31. Date filed (Month, Day, 1007) who completed car

M.D

12017 Ft. Washington Rd., Fort Washington, MD 20744

se of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State Registrar		State	OI IVI	arylari		ertificat				ientai ny	Reg. N	20	1 1	335	595
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Examin		4a. Facility Name (if CORSICA	HILLS 1	-				CE	NTRE	VILL				C. County	of Death	E'S	
Funeral Director		5. Social Security No. 427–68–1		6. Sex 1 ☐ M 2 🔀 F		e (In yrs. Ia 73	ast birthday Yrs.) If Unde Months	Days	If Unde Hours	Min.	8. Date of Bit 11/25/		7	9. Birth Coun MISS	olace (State c stry) ISSIPF	or Foreign PI
how at	ř	Usual Residence of 10a. State	Decedent 10b. County			10c. City	v. Town or	ocation							1	I 0d. Inside Ci	ity Limits
farylar Ba-f sl tified	Director	MD	QUEEN	ANNE'S		S'	TEVEN	SVILLE	E							1 🗌 Yes	s 2 🔀 No
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ould be filed with d Mental Hygien marked other th matic event, the	To B	17. Father's Name (I	First, Middle, L N RONE									e (First, Middle HOLLOW		Surname	e)		
Dor no		19a. Informant's Na						-				Route Numb					
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permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra		4 Donation	5 Other (S		m State	CHE	<u>CE</u>	KE CRE				7/2011				E, MD	
permi Depar Impo any ir		21. Signature of Fur	neral Service I	Licensee	l		_	FELLOV 106 SH	d Addres IS IAMRC	ELFE CK R	NBEII	N & NEW CHESTE	NAM R, 1	FUNI MD 21	ERAL 1619	HOME,	P.A.
Physician/ Medical		23a. Part 1. Enter t shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List o Final	only one cause on	each lin	reb	h. Do not e		le of dying	g, such a	s cardiac d					Approxima Interval Be Onset and	te tween
Examiner		Sequentially list co	nditions	Due t	Hy Hy	a consequ	ence of:	n _				_				years	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. Within 24 hours after death. Completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 1 1 ☐ Yes 2 9 ☐ Unknown	months? No		e Birth egnant a		al death 3	Ectopic Other (s)		;у					nte of deliventh	•	Year
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nding Ph ath. r: After thi e funeral	Certificate:	27. Manner of Death Natural 2 Accident	5 Pendir	ig .	te of inju onth, Da		28b. Time injun		28c. Injury work 1 \Box	y at		28d. Describe					
tal or Atters after de al Directo		3 ∐ Suicide 4 □ Homicide	6 U Could determ	inad 28e. Pla		ury - At ho c. <i>(Specify</i>		street, factor	y, office			28f. Location City or To			er or Rura	I Route Num	ber,
ne Hospit in 24 hour ne Funera pleted fille	Medical	(Check 2	Medical E	Physician: To the xaminer: On the b Nurse Practione	asis of e	examination	n and/or inv	estigation, in	my opinio	on, death	occurred a	t the time, date	and place	ce, and du	e to the ca	ause(s) and m	anner stated
To the To the COM		29b. Signature and	title of certifier	MAN	ahr	1 N	11)	290	c. License	number	933		29d. D	ate signe	d (Month,	Day, Year)	
300		30. Name and addre	ess of person	who completed ca	use of c	leath (Item	23a) (Type	, Print)	, /	m.	FA	ston	M	, 2	165	7	
Stat		31. Date filed (Monta	h, Day, Year	10 1 2 1 32.	Registr	ar Signat	ture	P.	ر من	write) handle	-1000			100	/	
Registra	ar	1	11111	18 U 7/17	N Z	KNOCAN	\sim ρ	. 1000	A CONTRACTOR OF THE PARTY OF TH								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.20 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ \$eptember 26 2011 Pauline Butler 5:15PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Crofton Convalescent Center Crofton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year, Months Hours 213-22-2011 **Director** 1 □ M 2**X** F 1920 Maryland 90 Yrs. Nov 11 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a. State Examiner must be notified at Director MarylandPrince George's Bowie 1 🗌 Yes 2 🛣 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4400 Oakview Lane 20715 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. Ş Q 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black marked other than "natural", Completed 3

▼ Widowed 4 □ Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical.] 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Crownsville Elementary/Secondary (0-12) College (1-4 or 5+) 12th 0 <u>Housekeeping</u> State Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wesley Turner Ida M. Grav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roosevelt Queen(Son) 4400 Oakview Lane Bowie, Md. 20715 20a. Method of Disposition 20b. Place Dispation (Name of cemetery, elematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Memorial Park 10-3-11 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Winame Reese of ScilitSons Mortuary, P.A. Harry 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the dil ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physician/ Jear) disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of If any, leading to immedicause. Enter Underlying Examir Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Records, 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 2 🗌 No 1 Yes Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No 4X Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death e Hospital or Attending Pt 124 hours after death. e Funeral Director; After the letely filled in by the funera 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Morth, Day, Year) 35848 cause of death (Item 23a) (Type, Print) Name and address of person who complete 1438Defense Aug Gambrille MD 21054

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Emile Louis Bernier 2020 PM October Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital Easton Eastor Talbot 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 🗶 M 2 🗆 F Months Days Hours April 1th, 100, 1920 New York 116-09-2797 **Director** 91 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 X Yes 2 No Marvland Caroline Denton items 23a or 3 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21629 420 Woods Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner Armed Forces?

1 X Yes 2 No 1941 Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates.to 1945 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 2 should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NYC Law Enforcement Manager 4 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bernier Marie Catherine Esquerre Emile Η. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 21629 Page 1 and 2 Michele Bernier/daughter 7071 Federalsburg Hwy. Denton, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State 11/10/2011 Arlington, Virginia Arlington Nat'l Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Moore Funeral Home, P.A. Denton, Maryland 21629 12 South Second Street 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Ph_{sician} Immediate Cause (Final Pulmonary tiprosis Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner neumonia Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Due to (or as a consequence or, Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal deat 4 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Amiodarone To xici+ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 13chaemic Colitis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. • Funeral Director: After this certificate has leted filled in by the funeral director, page 2 $^\circ$ autopsy 410 Astes performed? Yes 2 No Commary 1 ☐ Yes 2 ☐ No 25. Was case referred to predic Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျပ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending ☐ Accident Investigation Suicide 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 00069567 MI O ham October 12, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State
Registrar

DHMH 17 Rev 7/2009

Ravi Mohan, M.D.

31. Date filed (Month

Easton, Maryland 21601

219 S. Washington Street

		_ '	For State Registrar	State of Maryla		tificate of			Reg. N		
ı	Physicia	an/	1. Decedent's Name (First, Middle, Las	·				2. Date of De Month	eath 29	ay 2011	3. Time of Death 2:30 P M
- many	Medic Examir	cal	George Walton Bu 4a Facility Name (if not institution, give Bethesda Health a			4b. City, Town, o	r Location of Death		-	c. County of Death	2:30 P W
	LXaiiiii					Bethesd	a			Montgomer	у
	Funeral Director		5/9-/4-29/1	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month Da 03/29/			place (State or Foreign try) VA
	ind show at	ě	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				1	0d. Inside City Limits
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	h the la or 2 be no		10e. Street and Number		"	10f. Zip Code			0	Citizen of What Coun	•
	tth wit ms 2% must	nner	1845 Harvard Stree	12. Was Decedent Ever in		20009	lispanic Origin? (Sp	ecify Yes or No-		ited Stat	
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1X Yes 2 No If Yes, Give Year or Dates.	1	f Yes, specify Cub	dispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)		Black, White, e	etc.
2-0	hours 'natur dical l	olete	15. Decedent's Ed (Specify only highest gra	ducation		dent's Usual Occup	pation during most of work	dna	16b.	Kind of Business Inc	
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ılan	d be fill dental irked tic ev	₽	George Walton Bui	ch, Sr.			Sarah C	lark			
Maryland	should and N is ma auma		19a. Informant's Name/Relationship (Ty	, , ,	19b. Maili	ng Address (Street	and Number or Rur	al Route Numbe	er, City o	or Town, State, Zip C	Code)
2	and 2 Health em 27		George Walton Burd		7310		e Drive.	Lizella Date		A 31052 Location - City or To	vun Stata
nor	age 1 ant of 1 t: If it		1 🙀 Burial 2 🗆 Cremation 3 🗆	Domesial from State	cemetery, crer	natory or other pla	ce) atark10/0		I	comac, Vi	
Baltimore,	permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licens							Homes, P	
m	permi Depar Impor any ir		Charles E. 1	four _	5	538 Marl	boro Pike	, Fores	tvi	11e,MD 20	746
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-	Medical Examiner	ı	resulting in death)	Due to (or as a conse	equence of):						
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	cate be executed physician and s the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a conse	equence of):		-				-
3760	ate be hysicia the bur	dica		d							
Box 687	ath certificather ding for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of prec 1 Live Birth 2 F 4 Pregnant at time of	etal death 3	Ectopic pregnan Other (specify)	су			23d. Date of delive	ery Day Year
P.O.	that the dealed by the a		Part II. Other significant conditions co	entributing to death but not	resulting in the t	ınderlying cause g	iven in Part I.	23e. Did	tobacco	use contribute to th	ne cause of death?
ls, l	uires t n sign ald be	ed by						1 🗆	Yes 2	2 PNo 3 □ Prol	bably 4 🗆 Unknown
of Vital Records,	aw require as been s 2 should	Completed						24a. Was	psy	prior to co	psy findings available mpletion of cause of
Re	: The law r cate has b ; page 2 sh	Son				<u></u>		perf 1 🗌 Yes	ormed? 2	death?	2 No
ital	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Oth	lace of Death (Chec				
of V	y Phys er this eral di	e: 10	27. Manner of Death	1 ☐ Inpatient 2 28a. Date of injury	28b. Time o	28c. Inju	ry at	ome 5 ☐ Resi 28d. Describe		6 Other (Specify occurred	<u>) </u>
on	ttending I death. ctor: After y the funer	ficat	1 Natural 5 Pending 2 Accident Investigation		injury	M 1 🗆	k?] Yes 2 □ No				
Division	tal or Attend rs after death al Director; A ed in by the f	Il Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec		eet, factory, office		28f. Location (City or To		n d Number or Rural te)	Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direct completed filled in b	Medical	(Check 2 Medical Exami	sician: To the best of my knoner: On the basis of examinate Practioner: To the best of	tion and/or inves	tigation, in my opin	ion, death occurred a	at the time, date	and plac	ce, and due to the ca	use(s) and manner state
	vith To th		29b. Signature and title of certifier.	1		29c. Licens			29d. D	ate signed (Month,	
				Jan, MD			57124			10/4/11	
CK	0		30. Name and address of person who c						000		
	Sta	te	Troung Bao M. D. 31. Date filed (Month, Day Year)	32. Registrate Sig	Har Dri	ve, #206	, Rockvil	le, MD	208	5.0	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Boverman september Day 28, 6:40 P. M Margaret 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death **Examiner** Columbia Gilchrist Hospice Care Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Month, Day, Year) 1 🗆 M 2 👺 F 461-16-0237 Months Days Hours 90 Illinois Director Dec. Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland notified at Director Silver Spring Montgomery MD 1 XYes 2 ☐ No 10f. Zip Code 10e Street and Number 0 10g. Citizen of What Country? must be 14809 Pennfield Circle Apt. 201 Funeral 20906 23a United States items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Examiner Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event. The Martinal France. þ 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Public Health Educator College (1-4 or 5+) 5+ Public Health Service Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Broderson Maze Henry Nellie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4099 Linthicum Road, Dayton, mD 21036 Beth Ann Cobleigh/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Sept. Date 28 20c. Location - City or Town, State Geo: Wash work versity Medical Center 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4 X Donation 5 ☐ Other (Specify) Name and Address of Facility Columbia Mortuary Services, P.A. Signature of Funeral Service Licensee 9013 Annapolis Road, Lanham, MD 20706 /M00969 Shotz GCar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death ☐ Yes 2) ☐ Unknown No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 24a. Was an autopsy performe 1 Yes 2 **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2 200 ျှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 5 Pending injury Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatule and title of certil 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar and address of person who completed cause of death (Item 23a) (Type, Print)

0 5 2011

egistrar's Signature

11-07501 Colie Robert Benne	it, IV Sta 1- For State Registrar			Health and Mer	ntal Hygiene	Reg. No.	2011	3360
Physician/ Medical Examiner	Decedent's Name (First, Middle	Colie Robert Be	ennett IV		2. Date of I Month Octobe	Death Day er 6, 2011	Year	3. Time of Death 1816 hrs
	4a. Facility Name (if not institution Penninsula Regional M	-	14	b. City, Town, or Location Salisbury		4c. (County of Death	
Funeral Director	230-45-6255		yrs. last birthday) 29 Yrs.	Months Days Hour		f Birth(MM/D /29/1982		hplace (State or Virginia untry)
Maryland 28s-fshow any dat once.		comack	City, Town or Location	Chincot	eague			10d. Inside City Limits 1 X Yes 2 No
eath with the Maryland items 23a or 28a-f abo ust be notified at once. Imeral Director	10e. Street and Number 6280 Magnolia Dr			10f. Zip Code 2333	36	10g. Citize	n of What Coun US	
s after d		1 Yes 2 No	No 1	Decedent of Hispanic Ories, specify Cuban, Mexicar Yes 2 No specify.	n, Puerto Rican, etc.)	s	White, etc. V pecify:	can Indian, Black, Vhite
5-0036 ed within 72 hours yegiene. other Hand "natur the Medical Exam	15. Decedent's Education (Specific Elementary/Secondary (0-12)	College (1-4 or 5+)	d) 16a. Decedent during mo	s Usual Occupation (Give st of working life, DO NOT Truck Drive	use retired)		nd of Business/Ir	
215-(be filed by the sent, the sent, the Co	17. Father's Name (First, Middle, L Co	lie Robert Bennett	Ш	18.Mother	r's Name (First, Midd $R_{ m C}$	le, Maiden Si se Eller		
MD 21 3 2 should th and Mer 27 is man umatic even	19a. Informant's Name/Relationshi Rose Tatum Payn	, . , ,		Address (Street and Nur Box 780, Atlantic		Number, City	or Town, State,	Zip Code)
timore, MD 21215-00 1. Pages I and 2 should be filed without of Health and Mental Hygier reaut: If item 27 is marked other reaut: If item 27 is marked other or or other traumatic event, the MT To Be Cor	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Spe 21. Signature of Funeral Service Li	3 Removal from State	crematory or oth Fairview La	wn Cemetery	Date 10/9/2011	20c. Lo	Onanco	
Balt permit Depart Impor injury	John J. Willan	20.0	Wi	ame and Address of Facilit Iliams Funeral H	lome, PO B	-		s, VA 23417
Physician /Medical ;xaminer	23a Part I. Enter the disease, or confailure. List only one cause of Immediate Cause (Final disease or condition resulting in death)		Atherosc					Approximate Interval Between Onset and Death
caminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b. Due to (or as a consequence.	ce of):					
executed an and al - transit ical Exal	events resulting in death) Last	Due to (or as a consequence d.	ce of);					
O, be exect sician a purial - t	X UNPENDED			r me,g923 1-	18-12 sm			
certificanding page as th	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 Live birth 4 Pregnant at time o 9 Unknown	2 Feta	al death 3 Ectopio	c pregnancy		Date of delivery onth D	ay Year
, P.O. I res that the signed by th be detache d by Ph	Part II. Other significant condition Brain Tumor, By		ot resulting in the un	derlying cause given in Pa				he cause of death? ably 4 Unknown
Records, The law requirer ficate has been sig, page 2 should be					pe	as an atopsy erformed?		opsy findings available ompletion of cause of
ician: ician: s certifi rector,	25. Was case referred to medical examiner?	Hospital:	A EDIO ANTINA	26.Place of Death	(Check only one) Nursing Home 5	7.0		
	1 ✓ Yes 2 No 27. Manner of Death 1 ※ Natural 5 Pendin	28a. Date of Injury (Month, Day, Year)	✓ ER/Outpatient 28b. Time of In		? 28d. Descri	Residence		
2 2 2 2 2 1	2 Accident Investig 3 Suicide 6 Could r 4 Homicide	ation 28e. Place of Injury - A	At home, farm, street	factory, office building, et	c. 28f. Locatio	n (Street and n, State)	Number or Run	al Route Number, City
Fo the Hosy within 24 ho Fo the Fun Completely Completely Gedical C		sician: To the best of my know ner:On the basis of examination and manner stated						

State 31. Date filed (Month, Day, Year)
Registrar OCT 18

30. Name and address of person who completes

Theodore M. King, Jr., MD.

29b. Signature and title of certifier

sistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

cause of death (item 23a)

29c. License number

O.C.M.E.

OCME

29d. Date signed (Month, Day, Year)

October 7, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 32 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Howard Columbia 5. Social Security Number 6. Sex 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours 02/05/1943 Director 220-38-1095 West Virginia Usual Residence of Decedent 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sl aumatic event, the Medical Examiner must be notified: 1 Yes 2 No MD Howard Ellicott City 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3730 Crossbow Court 21042 U.S.A Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Deceded in Ever in 6.3.

Armed Forces?

1 ☑ Yes 2 ☐ No Navy
If Yes, Give
Year or Dates. 1965–1970 Black, White, etc 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Marketing Executive Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clarnece William Brockman Dorothy Shaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Barbara Brunstetter/Wife 3730 Crossbow Court, Ellicott City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 N Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ardent Cremation, Inc 10/18/2011 Hanover, Maryland 21. Signature of Puneral Service Licensee 22. Name and Address of Facility 730 2055 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Securificany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 2 🗌 No ed by the a detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown q | Unknown After this certificate has been signed by 'funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 Yes 2 🗆 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 မ 1 🗌 Yes 1 Department 2 ER/Outpatient 3 DOA 27. Manne of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending within 24 hours after death. To the Funeral Director At 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 0056

Registrar

COUNTY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 2011 4:15 A Elizabeth P. Culpepper 10 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Country) VA 1 □ M 2 □XF Days Hours Min. (Month, Day, 05 23 577-60-5566 Director 1910 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 No MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20782 USA 6322 23rd Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 1. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces Black, White, etc. 1 Never Married 2 Married "natural", or þ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Black Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Physical Account Clerk Navy Department traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mentall Important: If item 27 is marked o any injury or other traumatic eve ည Mary Elizabeth Williams Henry Madison Pegram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6322 23rd Avenue, Hyattsville, MD 20782 Evelyn Hider/Friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 10/07/2011 Suitland, MD 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service License 4217 9th St. NW, Washington, DC 20011 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death YEARS Immediate Cause (Final Physician/ 000 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate occor. Enter or denying Examine Due to (or as a consequence of): physician consist is the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Tectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant Unknown Pregnant at time of death 5 Other (specify) Day signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 1 Tyes 3 Probably 4 Unknown Completed page 2 should een 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death?
1 ☐ Yes 2 No autopsy performe this certificate within 24 hours after death.

To the Funeral Director: After this certific campleted filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA

Zate of injury
(Month, Day, Year) 28b. Time of injury
28c injury 1 🗌 Yes မှ Manner of Death 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 5 Pending Natural 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 40064588 0

Registrar

State

ASHISH

31. Date filed (Month, Day, Year)

OCT

TOUA

0 6 2011

CARROLL

2. Registrar's Signature

AUE.

TAKOMA PARK MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Mary Frances Crowe Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany Western MD Regional Medical Center Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 X Month, Day, Year) August 26, 1942 **Director** 69 Maryland 218-76-3468 Usual Residence of Decedent 28a-f show ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No LaVale Allegany Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Roger Way Funeral U.S.A. 21502-12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 K Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental filem 27 is marked ဂ Oscar Crowe Mary M. Wagus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21545-Maryland Karen Hook 16733 Dutch Hollow Rd. Mt. Savage 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Maryland 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Memorial Park October 03, 2011 Frostburg Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cau a on each line. Approximate on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine if any, leading to influedate cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last to (or as a conseque attending physician Physician/Medical for use as IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death signed by the at d be detached fo g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed: Yes 2 X death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 1 🗋 Yes ဂ္ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No М ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Hitying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to tr 29b. Signature and title 29d. Date signed (Month, Day, Year) 3 30. Name and address completed cause of death_(Item 23a) (Type, Print) Julie Bielec 32. Registrar's Signature State OCT 03 2011

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

Division of Vital

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Plea	ise Type or I					_		.egible.	
	-	For State Registrar	State of	Maryland	•	rtment of F ificate of L		wientai my	Reg. No?	n I I	33604
Physicia		1. Decedent's Name (First, Middle	, Last) ONNOY	-				2. Date of De Month	- Sam	30 Year 2	3. Time of Death
Medic Examin		4a. Facility Name (if not institution, Allegany Heal					Location of Deat Cumberla		4c. Cc	ounty of Deat	egany
Funeral Director		5. Social Security Number 220–16–5533	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. last 99		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi (Month, Di 06/08		Cot	hplace (State or Foreign Intry) 'yland
aryland a-f show ified at	Director	Usual Residence of Decedent 10a. State 10b. County MD	Allegany	10c. City, T	own or Loca	cumber	land				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
vith the M 23a or 28 st be noti	eral Dir	10e. Street and Number 11206 Butter	nut Lane,	NE		10f. Zip Code	21502		10g. Citizer	n of What Co US	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Marr	12. Was Deced	lent Ever in U.S. ces? 2 🙀 No	If '		ispanic Ongin? (S an, Mexican, Puert Specify:			. Race - Ame Black, White	e, etc.
hours and matural	letec		nt's Education		16a. Decede	ent's Usual Occup	ation	ding		of Business	White Industry
within 72 rgiene. her than " t, the Mec	Completed	Elementary/Seconday (0-12)	st grade completed) College (1-4	4 or 5+)	life. DO	Homemake	r	kirig		Hor	ne
ld be filed Mental Hy arked ott atic even	To Be	17. Father's Name (First, Middle, L James	Theod	ore I	wigg		18. Mother's Na Oka		, Maiden Sur D •	mame) I	McElfish
nd 2 shou ealth and m 27 is m		19a. Informant's Name/Relationsh Margaret Hauer		aughter	19b. Mailing 220	Address (Street Carrera	and Number or Ru Drive, T	ral Route Numb he Vill	er, City or To ages ,	wn, State, Zip FL 32	2 159
Page 1 ar nent of Hu ant: If iter ury or oth		20a. Method of Disposition 1 XBurial 2 Cremation 4 Donation 5 Other (S		007	crest		ıl Pairk 1		11 0		land, MD
permit. Departr Import. any inji		21. Signature of Funeral Service L	icensee				ss of Facility Ad r Street				Home, P.A. 21502
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. HYPE	ch line.	VZ		y such as cardiad			,E	Approximate Interval Between Onset and Death
	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (c	or as a consequer	nce of):						
ate be execu physician and the burial-tra	ш	that initiated events resulting in death) Last	c. Due to (c	or as a consequer	nce of):						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunial-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live E	come of pregnanc Birth 2 Fetal d ant at time of dea own	leath 3 🗌	Ectopic pregnand Other (specify)	су		23	d. Date of de Month	livery Day Year
uires that the signed by the signed by the detail	ed by Pi	Part II. Other significant condition	ons contributing to de	eath but not result	ing in the un	iderlying cause gi	ven in Part I.		tobacco use		the cause of death?
The law requate has beer page 2 shou	Complete							per	s an opsy formed?	prior to death?	ntopsy findings available completion of cause of
rsician: s certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	npatient 2 🗆 EF	3/Outnatient	_ Oth	er:	ck only one)	idence 6	Other (Spec	nifv)
nding Phy tth. : After this funeral c		27. Manner of Death 1 Natural 5 Pendir 2 Accident Investig	28a. Date o (Monti		3b. Time of injury	28c. Injur work	y at	28d. Describe			
al or Atters a stransfer des	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At homog, etc. (Specify)	e, farm, stre	et, factory, office			(Street and Nown, State)	Number or Ru	ral Route Number,
ne Hospitt n 24 hours ne Funera pleted fille	Medical	(Check 2 Medical E	Physician: To the be examiner: On the basis Nurse Practioner: T	s of examination a	nd/or investi	gation, in my opini	on, death occurred	at the time, date	and place, ar	nd due to the	cause(s) and manner stated
Within To the Congression		29b. Signature and title of certifier		anex	400	29c. Licens	e number - 1486	5	29d. Date :	signed (Mont	h, Day, Year)
T DAS		30. Name and address of person Robustiano J		e of death (Item 2	3a) (Type, Pr 200 G	rint)	reet, Cur			21502	
Stat Registra		31. Date filed (Month, Day, Year) OCT 0 3 201	1 Septem 32. Re	gistrar's Signatur	Sarks	/					

DHMH 17 Rev 7/2009

of the

State Registrar M.D. 6001 MUNCASTER MILL RD. ROCKVIL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. BINDU JUSEPH M.D. 60011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar 33606 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 14:35 P M CLOGG. 02, SR. OCT 2011 KENDALL DAVID /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ATLANTIC GENERAL HOSPITAL BERLIN, MARYLAND WORCESTER COUNTY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1X M 2□ F 71 Yrs MAR 10, 1941 DELAWARE 221-24-2338 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at SUSSEX COUNTY 1 Yes 2 No DELAWARE **DAGSBORO** Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 29157 MARTHA LANE 19939 UNITED STATES death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Menial Hyglene. Important: If Item 27 is marked other than "na eny injury or other traumatic event, Ita Mudic 2006. Elementary/Secondary (0-12) College (1-4or 5+) **GROUNDS KEEPER** LANDSCAPING 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHESTER LEE DELIA BRUMLY CLOGG P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HARTE (DAUGHTER) 34795 POPLAR NECK RD., PITTSVILLE, MD 21850 SHANA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DAGSBORO REDMEN CEM. OCT 7, 2011 DAGSBORO, DELAWARE 22. Name and Address of Facility MO 1361 WATSON FUNERAL HOME PO BOX 125 MILLSBORO, DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition CARDIAC ARREST resulting in death) /Medical Due to (or as a consequence of) Examiner SUDDEN DEATH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit The law requires that the death certificate be executed 15 YRS. that initiated events resulting in death) Last MITRAL_VALVE_DISEASE Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical the 95 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) □Yes 2 🗆 No o 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 X Yes 2 No 3 Probably 4 Unknown COPD Completed should peeu 24b. Were autopsy findings available prior to completion of cause of death? CARCINOMA TONGUE page 2 s has autopsy performed certificate 2 \ No 2 X No 1 Yes LUNG MASS, INCOMPLETE EVALUATION Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be funeral director 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. To the 29d. Date signed, (Month, Day, Year) 29b. Signature and title of certifier pleted cause of death (Item 23a) (Type, Print) agsboro 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month 10 201^{ear} 6:45 PM Andrew Eugene Clements Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Riverdale Genesis Crescent City Nursing Home If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 244-26-8385 1 ★ M 2 □ F Hours 06/13/1928 Director Usual Residence of Decedent items 23a or 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Examiner must be notified at Director DC Washington 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20019 4638 H Street, Southeast, #G02 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc Page 1 and 2 should be filed within 72 hours after doment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or i by 1 Never Married 2 Married 1 🔀 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2X No Specify: 3 ☐ Widowed 4 ᡮ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Entreprenuer 7th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luetta Holloway Johnny Clements 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1015 51st Street, Northeast, Washington, DC 20019 Vernessa Dickens/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State any injury 4 ☐ Donation 5 ☐ Other (Specify) HarmonyMemorial Cemetery 10/8/2011 Landover, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. M00981 5538 Marlboro Pike Forestville, MD 20746 23a. Part 1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each libe. e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Kidney Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) physician and the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Year 2 🗌 No 9 Unknown 9 Unknown Division of Vital Records, P.O. ģ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Completed 2 No 3 Probably 4x Unknown cate has been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 T-No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 🙀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 21 No မ 1 Inpatient 2 ER/Outpatient 3 DOA s after death.

I Director; After this d in by the funeral d 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours af To the Funeral Di completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated descripting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D0064208

State Registrar 32. Registrar Signature

4409 East West Hwy, Riverdale, MD 20737

30. Name and dress of person who completed cause of death (Item 23a) (Type, Print)

Saadia Husain, 31. Date filed (Month, Day, Year) OCT 0 7 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) October 4, 2011 Physician/ Doukmajian 1:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Holy Cross Hospital Montgomery If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Age (In yrs. last birthday) (Month, Day, Year, Hours 215-96-8286 **Director** 1X M 2 D F Aug. 16, 1964 Lebanon Usual Residence of Decedent or 28a-f show 10d. Inside City Limits of Health and Mental Hygiene. item 23a or 28a-f shore them 27 is marked other than "natural", or items 23a or 28a-f shore the traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2 XNo MD Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? Funeral 72 hours after death with 1601 Rainbow Drive 20905 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 K Married by 1 Yes If Yes, Give 2 🔀 No Specify.White Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Towing Business Owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Haroutioun Ohannes Doukmajian Ojene Aintabi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other traconce. Hasmig Doukmajian/Wife 1601 Rainbow Drive, Silver Spring, MD 20905 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Oct. 6, Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, MD 22. Name and Address of Facility Francis J. Collins Funeral Hom 500 University Blvd. W., Silver 21. Signature of Funeral Service Licenses Home Inc. MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Liver Metastases Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events 3 or Attending Physician: The law requires that the death certificate be executed after death. Peritoneal Metastases and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 No 1 Yes 2 L g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Severe Lymphedema of Lower Extremities, Malignant Ascites 1 🗌 Yes 2 🔀 No 3 🗌 Probably 4 🗀 Unknown Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been signed to the Funeral Director. After this certificate has been signed to the funeral director, page 2 should the funeral director. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforr 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2X No Hospital: ျှ 1 Tes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred 28c. Injury at Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 XNatural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

Jonathan Duran,

06 2011

31. Date filed (Month, Day, Year)

D66249

1500 Forest Glen Road, Silver Spring, MD 20910

Oct. 4, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	1 - State of Maryland / Registrar	Department of Certificate of			iene _{eg. No} 2011	33609			
П	Dhusisis	_,	1. Decedent's Name (First, Middle, Last)			2. Date of Deat Month		3. Time of Death			
	Physicia Medic		Mary Ann Dimond			October	4 2011	10:40 P M			
	Examin	er	4a. Facility Name (if not institution, give street and number)		n, or Location of Death		4c. County of Dea				
	Euroval	71	Wilson Health Care Center 5. Social Security Number 6. Sex 7. Age (In yrs. last bir		nersburg ar I f Under 24 Hrs.	8. Date of Birth	Montgo	nery rthplace (State or Foreign			
	Funeral Director			Yrs. Months Day	ys Hours Min.	June 3,	1931 Was	nington, D.C.			
	- MO		Usual Residence of Decedent 10a State 10b. County 10c City Tow					404 Issida Cital issita			
	ryland -f she ied at	ctor	100.000, 100.	wn or Location				10d. Inside City Limits 1 ☐ Yes 2 🕱 No			
	r 28a	Dire	Maryland Montgomery Gai	thersburg	le .		10g. Citizen of What C				
	with the 23a c	Funeral Director	333 Russell Avenue	2087		'	United St				
	eath v	Fune	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of	of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Am-	erican Indian,			
5-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If them 27 is marked alther than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates.	1 Yes 2 🔀	uban, Mexican, Puerto No Specify:	o Rican, etc.)	Black, Whi	te, etc. Thite			
ည	2 hou "natu edical	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working				Industry			
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Z 2	ed wit Hygie other	Be (17. Father's Name (First, Middle, Last)	пошещакет		ne (First, Middle, N		ome -			
<u>a</u>	be fil lental rked ric ev	잍	Matthew Gerald Walsh				lle Perry				
Maryland	should and M is ma		19a. Informant's Name/Relationship (Type, Print) 19	b. Mailing Address (Stre	eet and Number or Ru	ral Route Number,	City or Town, State, Z	ip Code)			
Σ.	nd 2 s ealth m 27			22 Maryland							
Baltimore,	ge 1 and tof H it of H or oth		1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State cemeter	of Disposition (Name of tery, crematory or other p	olace)		20c. Location - City o				
	it. Page rument or rtant: If njury or ri			politan Cre		08/2011	Alexandri	a, VA			
g Ra	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee Ryan MS Hatta M01202	22. Name and Ad			neral Home thersburg,	MD 20877			
z.	hysician/	disease of condition									
	Medical Examiner		resulting in death) a. Due to (or as a consequence	of): accid	ents.	1	. 1	Interval Between Onset and De Jh			
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence		cureel	sever					
	at ted	Examiner	cause. Enter Underlying Cause (Disease or iinjury								
	cate be executed physician and sthe burial-transit	I Ex	that initiated events ' c. Due to (or as a consequence	of):							
9	ite be hysici he bu	edical	d								
289	certifica inding p use as t	/Me	IF FEMALE: 23b. Was decadent pregnant 23c. If yes, outcome of pregnancy								
ROX	death ce he attene ed for us	Physician/M	23b. Was decedent pregnant in the past 12 morths? 1				23d. Date of d Month	Day Year			
	the de by the ached	hysi	9 Unknown								
s, P.O.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending properties of the funeral director, page 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting Appetrace.		,		pacco use contribute t es 2 □ No 3 □	to the cause of death? Probably 4 Unknown			
Vital Records,	w requ	Completed	sechmonary Liseau, K	Zenol ins	ufficien	24a. Was a		utopsy findings available completion of cause of			
ě	The la	om	permonary Liseau, k	Listanger	icinone.	autops perfori	med2 death?				
<u>.</u>	sian: artifica ctor, I	Be (25. Was case referred to marical	26	S. Place of Death (Che						
=	Physic this or al dire	မ	1 Hospital: 1 Inpatient 2 ER/C 27. Manner of Death 28a. Date of injury 28b.	Outpatient 3 □ DOA			ence 6 Other (Spe	ecify)			
on of	To the Hospital or Attending Physiciam: within 24 hours after death and the Funeral Director, After this certifica completed filled in by the funeral director, it	Certificate:	27. Manner of Death 28a. Date of injury (Month, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be 20 Physical Country 28b.	injury v	njury at vork? □ Yes 2 □ No	28d. Describe ho	ow injury occurred				
DIVISION	tal or Att rs after d al Direct ed in by t		4 Homicide determined 28e. Place of Injury - At home, 1 building, etc. (Specify)	larm, street, factory, offi	ce	28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,			
	ne Hospi n 24 hou ne Funer pleted fill	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge only one) 1 Certifying Nurse Practioner: To the best of my knowledge on the best of my knowledge of my knowledge of my knowledge on the best of my knowledge of my know	I/or investigation, in my o _l	pinion, death occurred	at the time, date ar	nd place, and due to the	e cause(s) and manner stated.			
	S stiff		29b. Signature and title of certifier L. Rohert pirschhach un	1	ense number		Octoper				
			30 Name and address of person who completed cause of death (Item 23a)) (Type, Print)	201 RU	55866	Octoper 4 VENU	18.			
			L. ROBERT BIRSCHBACH	ins	CA17H2	LSBUR	26 hld 2	20847			
	Stat Registra		31. Date filed (Month, Day, Year) 22. Registrar's Signature	parket.							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Llovd Deremer Alvin 2011 1 1530 P M October Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Allegany Cumberland Devlin Manor Health Care Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1070871979 Hours 1 🛛 M 2 🗆 F Pennsylvania 91 Director 174-18-3335 Usual Residence of Decedent of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland Director Ridgelev 1 Yes 2 XNo WV Mineral 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 26753 Funeral Route 3 Box 44 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced White WWII Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done (life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Utility Company Lineman permit. Page 1 and 2 should be filed wit. Department of Health and Mertal Hygien Important: If item 27 is marked any injury or a... Be 18. Mother's Name (First, Middle, Maiden Surname) Charlotte 17. Father's Name (First, Middle, Last) Cessna Deremer ည Emanuel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Route 3 Box 44, Ridgeley, WV 26753 Shelvia M. Deremer / Wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Sunset Memorial Park 10/06/2011 Cumberland
22. Name and Address of Facility Lams Family Funeral Home, 21. Sign rur of Funeral Service Licensee 404 Decatur Street, Cumberland, MD KI Part 1. Softer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORONARY Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 L rem. _____ Pregnant at time of death Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 2 🗌 No detached 9 Unknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy completed filled in by the funeral director, page 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 X Nursing Home 5 Residence 6 Other (Specify) မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural 5 Pending 1 Yes 2 🗌 No 24 hours after death. Funeral Director: A Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October 3, 2011 D26907

State Registrar

nds

31. Date filed (Month, Day, Year)

Harjit S. Sidhu, M.D.,

. Registrar's Signature OCT 03 back

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Hariit S. Sidhu, M.D., 925 Bishop Walsh Road, Cumberland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 03, 2011 Physician/ Diane Lynn DeHaven 11:14 AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Gilchrist Columbia Hospice Inpatient Center Columbia If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 X August 20, 1952 59 Pennsylvania Director 167-54-1793 Usual Residence of Decedent ural", or items 23a or 28a-f show I Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗆 Yes 2 🕱 No Mt. Airy Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1023 Saint Michaels Road Funeral U.S.A. 21771-12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Marital Status Armed Forces?
1 ☐ Yes 2 🗶 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White item 27 is marked other than "natural", other traumatic event, the Medical Exal 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) Homemaker Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F မ Dorothy Blank Raymond D. Blank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 21771-Maryland daughter 1023 Saint Michaels Road Tonya Der Mt. Airy 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date = 6 1 X Burial 2 Cremation 3 Removal from State Department Important: If any injury or Pennsylvania Hyndman Cemetery October 06, 2011 Hyndman 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) months Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe certificate Yes 2 No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 105/10 ည 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 \(\text{Yes} 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the only one) 29b. Signature and title of certifier 30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar 33612 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:40P M Yvonne G. Diggs October 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Southern Maryland Hospital Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 7. Age (In yrs. last birthday) Hours Min (Month, Day, Year) Director 579-20-9301 1 □ M 2 😾 F 86 May 4 1925 Massachusetts or 28a-f show notified at death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No Md Prince George's Oxon Hill ò 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 20745 USA 859 Neptune Avenue items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc ò by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black "natural". Completed 3 ☐ Widowed 4 😾 Divorced Year or Dates ed other than "natue event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Health and Mental Hygiene. tem 27 is marked other tha other traumatic event, the N Federal Government Accountant Be 17. Father's Name (First, Middle, Last) unknown 18. Mother's Name (First, Middle, Maiden Surname) unknown ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oxon Hill, Md. 20745 Department of Health Important: If item 27 any injury or other to Lakishia Diggs / Daughter 859 Neptune Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 😾 Burial 2 🗆 Cremation 3 🗔 Removal from State cemetery, crematory or other place; 4 Donation 5 Other (Specify) Lincoln Cemetery 10/13/11 Brentwood, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fort Lincoln Funeral Home Brentwood, Md 3401 Bladensburg Rd. 23a. Part 1. Enter the shock, or heart ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner INFECTION I week TRACT Sequentially list conditions It say sading to immediate cause. Enter Underlying Cause (Disease or injury Preumoniae Infection the burial-transit Exam Llobsiella and that initiated events resulting in death) Last attending physician for use as the buria Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death been signed by the a should be detached 1 L Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No filled in by the funeral director, or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tyes 2 X No ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director; After (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be n 24 hours after de Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D67588 10 08 Lexington Pank Exploration drive

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:35 рм oct. 2011 Marion Dill Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Denton Homestead Assisted Living If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Delaware Months (Month, Day, Yea 221-18-4545 81 Director 5-29-1930 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Delaware Camden-Wyoming Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 19934 281 Pony Track Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Owned home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lily Tharp William Neidig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 281 Pony Track Rd. Camden-Wyoming, DE 19934 Watson Dill/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Odd Fellows Cem. 110/12/2011 Camden, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pippin Funeral Home, Inc. 21. Signature of Funeral Source Licensee 19934 19 W. Cam-Wyo Ave.Wyoming, DE 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ sidado. disease or condition resulting in death) Medical Due (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Due to (or de a consequence of,: Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Other (specify) Pregnant at time of death 9 Unknown signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) দ্রু ড়াওম্ভর Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 1 ☐ Yes 2 ☑ No Hospital: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1 Matural injury 5 Pending 2 🗌 No Investigation Accident after death Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State Registrar

only one 29b. Signature

31. Date filed (Month, Day, Year)

17

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3683 (

32. Registrar's Signature

0

151

hostank Rd

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

00053355

Preston MD

29d. Date signed (Month, Day, Year)

2011

11-07327

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Joseph Dorleann 33614 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Year September 29, 2011 1520 hrs Madical Examiner Joseph Dorleans 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Dorchester Cambridge Dorchester Genral Hospital If Under 1 Year 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24Hrs. **Funeral** Days Hours 23, 1947 Country) Haiti Director 591-01-4030 64 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 1 X Yes 2 No Dorchester Hurlock Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygerhe.
Important: If item 27 is marked in the "natural", or items 23a in 23a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21643 302 Mulberry Street Haiti Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 X Married Yes Specify: Black 4 Divorced If Yes, Give Year 1 Yes 2X No specify: 3 Widowed ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Poultry Industry 9 Sanitation Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elida Setoute Be Leney Dorleans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 302 Mulberry Street, Hurlock, MD 21643 Lynda Dorleans/Daughter 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place)
Federal Hill Cemetery 1 X Burial 2 Cremation 3 Removal from State 10/8/11 Federalsburg, Donation 5 Other Specify. ^{22. Name and Address of Facility}Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licens 7 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Èxaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transit Physician/Medical AMENDED UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death 5 icate has been signed by the att page 2 should be detached for 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has death? performed Yes 2 V No 2 No funeral director, 26.Place of Death (Check only one) 25. Was case referred to medical nr Attendiog Physician: Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: 2 ER/Outpatient 3 DOA After this 1 Yes 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month. Day.Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 V Natural 5 Pending 1 Yes 2 No death. Director: the Accident 2 Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) In the Hospital Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. Sept. 30, 2011 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

OCME

ORIGINAL

7. Age (In yrs. last birthday)

Yrs.

District Heights

10c. City. Town or Location

Certificate of Death

4b. City, Town, or Location of Death

Silver Spring If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

20747

1 ☐ Yes 2 ☒ No Specify:

10f. Zip Code

16a, Decedent's Usual Occupation

Firearms Specialist

= For State Registrar

5. Social Security Number

Usual Residence of Decedent

1 Never Married 2 ☐ Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Ralph J. Fisher

19a. Informant's Name/Relationship (Type, Print)

577-70-5532

10e. Street and Number

10a State

Physician

/Medical

Examiner

Funeral

Director

r 28e-f show

Direct

Funeral

þ

Completed

with the Maryland

1. Decedent's Name (First, Middle, Last)

Holy Cross Hospital

Cheryl Antoinette Fisher

10b County

6317 Pennsylvania Ave, #101

15. Decedent's Education (Specify only highest grade completed)

4a. Facility Name (If not institution, give street and number)

1 ☐ M 2 🖾 F

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:

College (1-4or 5+) 2+

Prince George's

_	1 and Health		Ashlee Louise Fis	her/Daught	er 631	/ Pennsy	Ivania Ave	ل و ا	rstric
0	_ = = =		20a. Method of Disposition		20b. Place of D	isposition (Name	of	Date	
	permit. Pages 1 and Department of Healt Important: if item 2! any injury or other i		1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			ciematory`or othe Le Park (Crematory 10	/05	/2011
Ē	permit. Pa Departmen Important: Iny injury		21. Signature of Funeral Service Licen	500		22. Name and A	ddress of Facility	Pop	e Fune
<u> </u>	Depa Impo any ii		Hart a. J.	1010	85	5538 Man	clboro Pik	٤, .	Forest
			23a. Part1. En -r the diseas - or com- shock, or heart failure. List only	plications that caused to cause on each line	the death. Do not e.	enter the mode o	f dying, such as cardia	IC OF TE	spiratory arr
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Card	iopulmona	ary Arre		Part I. 2	
	Examiner			,	consequence of)				
	*		Sequentially list conditions.		nary Arte		ase		
	п #	ne	if any, leading to immediate cause. Enter Underlying	Due to (or as a	(io eunsequence of)	•			
	d	Examiner	Cause (Disease or injury that initiated events	End S	Stare Rei	nal Disea	ase		
	exec n an ial-tr	EX	resulting in death) Last	Due to (or as a	consequence of)	:			
CO CO CO	or Attending Physician: The law requires that the death certificate be executed siter death. Director: After this certificete has been signed by the ettending physicien and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical I		d.					
2	ficat phy s th	edi							
<	ding	Š	IF FEMALE:	23c. If yes, outcome of	of pregnancy				
3	ath etter for u	iar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at t	2 Fetal death	3 Ectopic pregi			
j	e de	Sic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9□ Unknown	ume or death	5 Other (speci	(y)		
•	w requires that the de been signed by the should be detached	Ph)			atai i at		on any or in Book!	-	23e, Did to
- (25.5)	gner bed	þ	Part II. Other significant conditions of	ontributing to death bu	t not resulting in tr	ne underlying caus	se given in Part i.		
3	aquir en si ould	Completed by	Diabetes						1 🗆 Y
3	b be	je						ĺ	24a. Was a
2	he la s has ge 2	Ē							autop: perfor
1101	r: Ti	ပိ							1 ☐ Yes
	ciar	Be	25. Was case referred to medical examiner?	Hospital:				ath C	check only or
-	his c	은	1 ☐ Yes 2 ☑ No	1.IX Inpatier			Other: 4 Nursing		
	ng P ter t	Ë	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	y 28b. Tin Year) Inju	ne of 28c	Injury at Work?	280	I. Describe h
5	ndir ath. r: Af e fu	atic	2 Accident investigation	1		M	1 ☐ Yes 2 ☐ No		
2	Atter deg	Ę	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of inju	ry - At home, farm	, street, factory, o	ffice	28f	Location (S
5	efte Oir Jin t	Certification:	4 Homicide	building, etc.	. (Specity)				City or Tow
	spite ours nerei		29a. Certifier 1 🛛 Certifying Ph	ysicien: To the best o	f my knowledge, d	leath occurred at	the time, date and place	ce. and	due to the c
	To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funeref Director: After this certificete has completely filled in by the funeral director, page 2.	edicai		niner: On the basis of and manner stat	examination and/				
	the the	Me	29b. Signature and title of certifier			290	icense number		
	5 ± ₹ 5	_	230. Signature and title of certified	()		255. 2			
				X		D6:	2571		(
	10		30. Name and address of person who	completed cause of de	ath (Item 23a) (Ty	/pe, Print)			
_			Sarah Bromeland	1500 Fores	st Glen I	Rd, Silve	er Spring,	MD	20910

33615 State of Maryland / Department of Health and Mental Hygien ? 2. Date of Death 3. Time of Death Day Month Year Рм 09/27/2011 22:02 4c. County of Death Montgomery Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 09/13/1949 DC10d. Inside City Limits 1⊠Yes 2□No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: Black 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) Kathleen Louise Douglas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ict Heights, MD 20747 20c. Location - City or Town, State Riverdale, Maryland eral Homes, P.A. tville, MD 20747 Approximate Interval Between Onset and Death 23d. Date of delivery Day Year Month tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s an 2⊠ No one sidence 6 Other (Specify) how injury occurred (Street and Number or Rural Route Number, own, State) e cause(s) and manner as stated. date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

OCT 0 7 2011

11-07691 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Gage Michael Fouche 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 14, 2011 0731 hrs **Medical Examiner** Gage Michael Fouche 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreignMaryland Country) Months Days Hours Director 217-31-4146 02/20/1991 20 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 103 10a State 10b. Count 10c. City. Town or Location 1 X Yes 2 No 28a-f show Brunswick Maryland Frederick hours after death with the Maryland 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 21716 United States 20 N. Virginia Avenue 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14 Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes Specify: White 1 Yes 2 X No specify: 3 Widowed 4 Divorced If Yes, Give Year permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygione. Imprantant: If item 27 is marked uther than "natural", Impurant: If item 27 is marked uther than "natural" injury or other traumatite event, the Medical Examiner. ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Automotive Repair Mechanic 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ashley Fouche, Jr. Lisa Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Fouche / Mother 20 N. Virginia Ave., Brunswick, MD 21716 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Oct. 17. 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Resthaven Crematory 2011 Frederick, Maryland 4 Donation 5 Other Specify:
21. Signature of Fineral Service Lice see 22. Name and Address of Facility
Resthaven Funeral Services, Skkot Cody P.A. MD 21701 9501 Catoctin Mountain Hwy. Frederick, Approximate Interval complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease **Physician** Between Onset and failure. List only one sause on each line. Medical Death Immediate Cause (Find disease aOxymorphone Intoxication Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed Physician/Medical AMENDED 23a, 27, 28a-f, per me, g922 12-9-11 sm **X** UNPENDED the attending physician led for use as the burial -The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by 1 be detache Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ě 1 Yes 2 No 3 Probably 4 V Unknown Completed certificate has been ector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: After this 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Natural Director: 5 Pending 1 Yes 2 X No unknown within 24 hours after death.

To the Funeral Director: fd 10-14-11 fd 0630 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 20 North Virginia Ave Brunswick, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide residence determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME October 15, 2011 Ce 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Zabiullah Ali, M.D. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

RECAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Jose Ovidio Guzman 00.06AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** General Hospital rsmostra rsmortia If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 1 ☎ M 2 ☐ F 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Country) 1 Salvador 43 **Director** (Unav. December Usual Residence of Decedent 28a-f show 10b. County any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Hyattsville Maryland Prince George's 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 9010 Adelphi Road 20783 El Salvador within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Ö 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 🖾 Yes 2 🗆 No Specify: Salvadorian "natural", Hispanic Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Wholesale Truck Driver 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o ဂ္ဂ Jose Calazan Guzman Ofelia Romero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rigoberto Guzman / Brother 501 Alexandria Avenue, #7, Los Angeles, CA 90004 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State Metropolitan Crematory 10/10/2011 | Alexandria, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RAY Rogers 23a. Part 1. Enter the issease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sq Physician/ wanion disease or condition Medical resulting in death) (or as a consequence of): Due Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last ysician a e burial-Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 3 Probably 4 Unknown Completed s been signated the should the 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed Yes 2 certificate 1 🗌 Yes 2 4100 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner 2 No Hospital Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 2 🗌 No M 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifler Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2<u>011</u> Physician/ Hung Huynh 4, October ам 4:01 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 8. Date of Birth (Month, Day, Oct. 8, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, Days Hours 1 🛣 M 2 🗆 F 217-11-0087 **Director** Yrs. Vietnam 81 0ct. Usual Residence of Decedent 28a-f show 10a. State 10b. County aţ 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 🗌 Yes 2 🔀 No MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral 1004 Caddington Avenue 20901 USA i "natural", or item edical Examiner n 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes If Yes, Give 2 X No Asian 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Wareho<u>use Worker</u> Party Rental Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Tho Huynh Page 1 and 2 should be Tu Thi Luong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Xo Luong/Wife 1004 Caddington Avenue, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 1 ^XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 9,201 Oct. 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cemetery Adelphi, Maryland Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring,MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of) **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician the buria Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day ate has been signed by the a page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Sepsis Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XXJnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate 1 Yes 2 No Yes 2- No completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No after death. 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

Irina Rubán,

Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

MD

06

29c. License numbe

D63343

1500 Forest Glen Road, Silver Spring, MD 20910

29d. Date signed (Month, Day, Year)

October 4, 2011

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		for State Registrar		State of Ma	aryland		irtment of F tificate of D		,	giene Reg. Na	2011	33619		
Dhysisis	· · · /	1. Decedent's Name (F	First, Middle, Las	t)					2. Date of De Month	ath		3. Time of Death		
Physicia Medic				LBERTA HI	LL				Octobe	r 4	2011	3:10 A M		
Examir	er	4a. Facility Name (if no Manor Car		·			4b. City, Town, or Bethes		1		County of Dea			
Funeral		5. Social Security Num	ber 6. Se	x 7. Age	(In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Bir	thplace (State or Foreign		
Director		577-46-24	187	□ M 2 🙀 F	75	Yrs.	Months Days	Hours Min.	Nov. 13	, Year) 19	35 Vir	untry) ginia		
and show	ō	Usual Residence of De 10a. State 16	0b. County	- "	10c. City,	Town or Loc	ation					10d. Inside City Limits		
Maryla 28a-f a	Funeral Director	MD	Montgome	ery	Sil	ver S	pring					1 ☐ Yes 2 🛣 No		
a or 2 be no	Ē	10e. Street and Number	er			-	10f. Zip Code			10g. Citi	izen of What Co	ountry?		
th with ms 23 must	iner		wick Cou	irt, Apt.			20906				ted Sta	tes		
within 72 hours after death with the Maryland gignen. er than "natural", or items 23a or 28a-f show. the Medical Examiner must be notified at	β	11. Marital Status 1 ☐ Never Married 3 🏿 Widowed 4 ☐		12. Was Decedent Ev Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates.			/as Decedent of Hi Yes, specify Cubar		pecify Yes or No- o Rican, etc.)		14. Race - Ame Black, Whit Specify: Bla	e, etc.		
2 hour	plet	(Specify	15. Decedent's Ed	lucation de completed)			ent's Usual Occupa ind of work done d		kina	_	ind of Business			
e filed within 72 hour ital Hygiene. ed other than "natul event, the Medical	Completed	Elementary/Second		College (1-4 or 5-	+)	life. DC	NOT use retired)	-	9	D≁	ivate H	lome.		
lled will Hygik other	Be	17. Father's Name (Firs	st, Middle, Last)			1613	Soliai Coc	18. Mother's Nar	ne (First, Middle,			TOME		
d be f denta Menta arked aric ev	မ	Clifford	W. Thorr	nton, Sr.				Bessie	Lee Cha	mp	·			
shoul and I		19a. Informant's Name	1 1 31	<i>'</i>			g Address (Street a			-		•		
and 2 Health tem 2 ther t		David N. 20a. Method of Dispos		on	_		Chiswick ition (Name of	Court, A			ver Spr			
permit. Page 1 and 2 should be filed within 75 Department of Health and Wartal Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once.		1 🔀 Burial 2 🗍 4 🗌 Donation 5	Cremation 3 Other (Specify	-	cen	ton U	atory or other place nion Cem.	10/	Date 7/2011	Cli	fton, V	'A		
permi Depar Impo any ir		21. Signature of Funer		EC0208			Name and Addres		8 Inc. M	914 anas	Quarry sas, VA	Road 20110 _		
Physician/	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death		
Medical Examiner		resulting in death)	itions	Due to (or as a										
uted Id	Examiner	Sequentially list condi- if any, leading to imme- cause. Enter Underlyin Cause (Disease or iinju- that initiated events	ng 📉	Due to (or as a	consequer	nce of):								
icate be executed graphysician and is the burial-transity	edical E	resulting in death) Las	t L	Due to (or as a	consequer	nce of):								
certifica ending p use as t		IF FEMALE: 23b. Was decedent pre	anont 2	3c. If yes, outcome o	f pregnanc	·V					201 5-1(-1-			
the death c by the atten ached for u	Physician/M	in the past 12 mod 1 Yes 2 N	giiaii	1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Fetal d	death 3 🔲	Ectopic pregnancy Other (specify)	/			23d. Date of de Month	Day Year		
s tha	ठ	Part II. Other significa	nt conditions co	ntributing to death bu	t not result	ing in the un	derlying cause give	en in Part I.		obacco us	^	the cause of death?		
: The law re cate has be ; page 2 sh	Completed								24a. Was autop perfo 1 \square Yes		prior to	topsy findings available completion of cause of		
sician certifi irector	m	25. Was case referred to examiner? 1 \(\sum \text{Yes} \) 2 \(\sum \text{N} \)	_	lospital:			Othe	ce of Death (Chec						
ding Phy th. After this funeral d	cate: To	27. Manner of Death	D Pending Investigation	1 ☐ Inpatier 28a. Date of injury (Month, Day,	28	3/Outpatient 3b. Time of injury	3 □ DOA 28c. Injury work?	4 Nursing H	ome 5 Resid			ify)		
al or Atter s after des il Director ed in by th	28a. Date of injury 28b. Time of injury 28c. Injury at work? 2											ral Route Number,		
he Hospit in 24 hour he Funera pleted fille	29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
To the with Common of the table of the table of the table of table		29b. Signature and title	of certifier	Wenc	o ca	0	29c. License	number 5712			e signed (Mont/			
		30. Name and address												
Stat	0	Troung B 31. Date filed (Month, D					rd., Beth	esda, MI	20817					
Registra	-		0 6 2011	3. Registrar	A.	par								

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33620 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Horwath Gary 2011 10:22P M Wayne October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8920 Brink Road Montgomery Laytonsville Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) **Director** 218-50-0157 1 🗙 M 2 🗆 F 64 June 23 1947 Maryland 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Laytonsville Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20882 United States 8920 Brink Road 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1968and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married þ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify White Completed 3
Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Owner-Manager Stairs and Rails Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ည Horwath Doris Urma Sarver Walter John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code . Page 1 and 2 sh treent of Health a tant: If item 27 is 8920 Brink Road, Laytonsville, Maryland 20882 Angelique Horwath / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 M Cremation 3 Removal from State Metropolitan Crem. 10/08/11 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Puneral Service License Muriel H. Barber Funeral Home 22. Name and Address of Facility · Juna P.O. Box 5038, Laytonsville, MD 20882 Approximate Interval Between Onset and Death 1½ years 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No ed by the a 9 Unknown 9 Unknown P.O. signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 Yes 2 No Physician: 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner' Hospital 2 🗹 No Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After injury 1 🗹 Natural 5 Pending neral Director: Aft y filled in by the fur 1 Yes 2 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and titleof 29c. License number 29d. Date signed (Month, Day, Year) October 5, 2011 D 43083

Registra

State

6420 Rockledge Drive, #4200, Bethesda, MD

20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatur

George A. Sotos, M.D.

31. Date filed (Mogh Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October $2011^{\rm ear}$ Ruth Elizabeth Hignutt Medical 5:00 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Envoy of Denton Denton Caroline **Funeral** 5. Social Security Numbe 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 X F Months Director April 18, 1927 048-20-1864 Connecticut Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Maryland Caroline Greensboro 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 414 Bernard Avenue 21639 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Black, White, etc 3 Divorced 1 ☐ Yes 2 X No Specify: Completed Specify: White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Line worker Food processing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Albert Henderson Helen Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl Hignutt/spouse Department of Health Important: If item 2 any injury or other 414 Bernard Avenue Greensboro, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Eastern Shore Veteran's Cein. 10/13/2011 Hurlock, Maryland . Signature of Funeral Service Licer 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a conjequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examine Due to (or as a consequence of): ²⁴ Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
⁵ Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month been signed by the should be detached Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? erebro vascular accident 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy page 2 s 24b. Were autopsy findings available prior to completion of cause of performed? Yes 2 No death? 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No. filled in by the funeral director, To Be 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 1 Yes 2 No Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 14 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Gettifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D00475 10/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wafik Zaki, 836 South 5th Avenue M.D. Denton, Maryland 21629 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33622 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Donald Hager 22.30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Allegany Western MD Regional Medical Center Cumberland Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗷 M 2 □ F Days Hours 214-16-2047 Jan. Day 9 1921 Maryland **Director** 90 Usual Residence of Decedent 28a-f shov "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD LaVale Allegany 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 13001 Gramlick Road, SW U. S. A. should be filed within 72 hours after death vand Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Bace - American Indian. Armed Forces? 1942 þ 1 Never Married 2 X Married 2 🗆 No Baltimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 🙀 No Specify: 3 Divorced Specify: White Completed 1945 Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineer Tire Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel Joan (Davis) Hager Charles William Hager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13001 Gramlick Road, SW, LaVale, MD Valena Marie Hager Spouse 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State Restlawn Mem Gardens Oct. 18,2011 LaVale, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hafer Funeral Service, ohn 1302 National Hwy., LaVale, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown the a g 🗌 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 4 No 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica To Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending 2 Accident
3 Suicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 E Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) an

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State

Registrar

garko

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 33623

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September Day 30, Ž011 Dorothea Hagemeyer Рм 6:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Talbot Heartfields Assisted Living Easton If Unde 9. Birthplace (State or Foreign New York Social Security Number . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🛚 F Months Min Hours 1171371915 055-14-1192 **Director** 95 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nature". 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Talbot Cordova 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 31770 Bishop Drive 21625 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify. Completed 3 X Widowed 4 Divorced Specify: White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph P. Morgan Ann Tynan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Amoroso/daughter 31770 Bishop Drive, Cordova, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 11 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Wilmington&Brandywine Cem. 10/4/2011 Wilmington, Delaware Signature of Funeral Service Licenses 22. Name and Address of Facility Torbert Funeral Chapel Will Taw Tor Dover, Delaware 19904 South Bradford Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician WHA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Adss. VC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner De to (or a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit INNY Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnapt 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month Day Pregnant at time of death the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy performe death? within 24 hours after death.

To the Funeral Director, After this certificate Yes 25. Was case referred to a dical 26. Place of Death (Check only one) Be examiner? 10 6 Sther (Specif Assisted Living Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence f Death 27. Mann 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who com ed cause of death (Item 23a) (Type, Print) III./MD 503 Cynwood Drive Easton, Maryland Ludwig Eglseder, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ 6:57 A M Bertha Howerton October 2011 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Takoma Park Washington Adventist Hospital 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Jan. 30) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Year) 1938 North Carolina Hours 1 □ M 2 💢 F 578-54-4640 73 Jan. **Director** Usual Residence of Decedent 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location death with the Maryland 10a. State **Funeral Director** 1 X Yes 2 No Hyattsville Prince George's MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S. 20785 410 Warfield Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 2 1 Never Married 2 Married African-American Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 - Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Postal Service Postal Clerk 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even မ Bertha Burden Braxton Yelverton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 410 Warfield Drive Hyattsville, MD 20785 Renee Exton-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery Oct. 13 2011 Brentwood, MD 4 Donation 5 Other (Specify) 21. Signature Ameral Service Licenses 22. Name and Address of Facility Bonnette & Assoc. Funeral Home 2504 28th St., N.E., WDC 20018 23a Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner ten, Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events <u>e</u> Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) ₹No sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe 1 Yes 2 No After this certificate Yes 2 hours affer death.

Ineral Director After this certific
d filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ER/Outpatient 3 DOA 1 Inpatient 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred injury 1 🔀 Natural 5 Pending ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29b. Signature and title of certifier 52326 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

James K. Lightfoot,

31. Date filed (Month, Day,

OCTO

MD

7600 Carroll Ave., Takoma Pk, MD 20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mary	•		nt of He te of D			Reg. No.	011	33625			
			Decedent's Name (First, Middle, Las	t)					2. Date of Dea	ath Day	Year	3. Time of Death			
П	Physicia /Medic		Winfred Frank	Isbell					10	15 Day	2011	11:45 A ^M			
-	Examin		4a. Facility Name (If not institution, give			1		ocation of Death			ounty of Death				
			Transitions Nursi 5. Social Security Number 6. Se		yrs. last birthday)	_	kesvi	ITUNDER 24 Hrs.	8. Date of Birt		rroll g. Births	place (State or Foreign			
ı	Funeral Director			^{2X} M 2□ F 69	Yrs.	Months		Hours Min.	8. Date of Birt (Month, Da 08/10/	y, Year) 1942	Coui	PA PA			
	ed within 72 hours after death with the Maryland tygiene. Ner than "natural" or items 23a or 28a-f show it, the Medical Evantina, must be netified at		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation					1	0d. Inside City Limits			
	Maryl -f sho	to	MD Carroll	7	vestminst	er						1 Yes 2 No			
	r 28a	Director	10e. Street and Number				p Code			10g. Citize	en of What Cour	ntry?			
	th with	al D	56 Carroll St.				2115			USA					
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Dece If Yes, sp	edent of His ecify Cuban	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14					
36	rs afte	by F	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 ∰No If Yes, Give Year or Dates:		1 ☐ Yes	2 ₹ No	Specify:		s	Specify: V	Mhite			
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Maryland	d be fi ental I ked ol ic eve	To Be	Winfred Frank Is	bell				Unknow		niagie, maiden Surname)					
ary	shoul and M s mar umati		19a. Informant's Name/Relationship (19b. Maili	ng Addres	ss (Street ar	nd Number or Ru	al Route Numb	er, City or	Town, State, Zi	Code)			
Ž,	and 2 salth s		Roberta Isbell/wif					, Westmi							
ore	ges 1 at 1 of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐						Date						
Baltimore,	rtmen rtant:	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation, Inc. 10/20/2011 Hampstead 22 Name and Address of Facility Pritts Funeral Hom													
Bal	Depa Impo any is		21. Signature of Funeral Service Censee 22. Name and Address of Facility Pritts Funeral Home & Chapel, F												
			23a. Part 1. Enter the disease, or companies shock, or heart failure. List only	one cause on each line.								Approximate Interval Between Onset and Death			
The state of the s	_		Immediate Cause (Final disease or condition resulting in death)	a. Athe	ru scle	ohic	Cov	dova.	16 mlas	MD 21157 20c. Location - City or Town, State 1 Hampstead, MD Funeral Home & Chapel, PA stminster, MD 21157					
·			resulting in death)	Due to (or as a co	nsequence of):						tizen of What Country? SA 14. Race - American Indian, Black, White, etc. Specify: White Gind of Business/Industry Craftsman In Surname) or Town, State, Zip Code) 21157 Location - City or Town, State Impstead, MD al Home & Chapel, PA Ster, MD 21157 Approximate Interval Between Onset and Death Onset and Death 23d. Date of delivery Month Day Year Duse contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify) ury occurred and Number or Rural Route Number,				
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	nsequence of):							,			
	ecuted nd rransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c											
60,	be exe ician a burlal-	al Ex	resulting in death) Last	Due to (or as a co	nsequence of):										
58760,	ficate physis the I	edical		d											
Box (n certii anding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		□ Fatani	pregnancy			2:					
O. B	e death he atte	Physician/M	in the past 12 months? 1 □Yes 2 □No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown		Other (Month	Day Year			
P.0	hat the		9 ☐ Unknown Part II. Other significant conditions of	ontributing to death but no	ot resulting in the	underlying	cause give	n in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?			
Records,	n sign	d by			- 16-				ηz	Yes 2□]No 3□ Pro	obabiy 4 ☐ Unknown			
S	aw rec Is bee 2 shou	Completed							24a. Was		24b. Were aut	opsy findings available			
~	The la	om							perfe 1 □ Yes	ormed? 2 No	death?				
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of Vital	nat the death certificate be executed to be the attending physician and inetached for use as the burial-transit		1 Yes 2, ZiNo	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie		_	4-EL Nursing H				sify)			
on o	ding h. After fune	tion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Ye		М	28c. Injury Work 1 □ Y	? ? ⁄es 2 □ No	200. Describe	now injury	ooduned				
Division	Atten r deat ector: by the	ifica	3 Suicide 6 Could not be determined		- At home, farm, s	treet, fact	ory, office			(Street and		ral Route Number,			
Ö	ital or irs afte ral Dir	Certification: To										otatad			
	Hosp 24 hou Funer	Medical	29a. Certifier (Check only one) Certifying Place 2 Medical Example 2 Medical Example 1	nysician: To the best of miner: On the basis of ex	amination and/or i	ath occurr investigati	ed at the tim on, in my op	ne, date and place pinion, death occu	e, and due to the urred at the time	e cause(s) , date and	and manner as place, and due	to the cause(s)			
	Fo the within Fo the comple	Mec	29b. Signature and tile of certifie			2	9c. License			29d. Date	e signed (Monti	n, Day, Year)			
			15-				DC	13725		(0		: -			
	~ An		30. Name and address of person who				D -	and 0	Morh-	11-1	4	10			
	J		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	40	40	0	0-111	r (IN)	72 2	1157			
	Sta		OCT Q 1 2		h la	arka									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	For State Registrar		State of Ma	aryland	-	artment of F tificate of E		ı ivlen		lene Reg. No.	20		33626
Physicia	n/	1. Decedent's Name	e (First, Middle, Last)			V S	~")			Date of Dear	th Day	7.	Year	3. Time of Death 5 40 ρ M
Medic Examin	al .	4a. Facility Name (if	not institution, give stre		HC	<u> 15</u>	4b. City, Town, or	Location of Dea		9		County of		
Examilia	eı	, ,	illmeade S		rive		Bowie				Prince George's			orge's
Funeral		5. Social Security No	umber 6. Sex	7. Age	(In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Date of Birth Month, Day,		,	9. Birthp Count	lace (State or Foreign try) VA
Director		577-52-3 Usual Residence of	711		/3						1950			
yland f shov ed at	tor	10a. State	10b. County			, Town or Lo	cation						11	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
r 28a- notifie	Direc	MD 10e. Street and Nun	Prince Ge	orge's	Bowi	Le	10f. Zip Code				10a. Cit	izen of W	hat Coun	
with th	Funeral Director		11meade St	ation Dr	ive		20720				USA			
iteath v	Fune	11. Marital Status	12	Was Decedent E	vor in 11 S	. 13.\	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (n, Mexican, Pue	(Specify 'erto Rica	Yes or No- n, etc.)			- America	
after c	d by	1 Never Marr 3 Widowed	ied 2 Married	Armed Forces? 1 Yes 2 If Yes, Give 19 Year or Dates.	154-	- 1	I ☐ Yes 2 🔀 No						B1ac	
hours natura lical E	Completed by		15. Decedent's Educ	ation	962	16a. Dece	dent's Usual Occup	ation	orkina		16b. Ki	ind of Bu	siness Inc	dustry
nin 72 ne. han " " e Med	dwo	Elementary/Sec	ocify only highest grade onday (0-12)	College (1-4 or 5	+)	Ìife. D	O NOT use retired)	126 . 26					2 C C	Transit
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be file lental I rked c														
should and M is mai			ame/Relationship (Type			1	ng Address (Street							
and 2 s lealth om 27 her tra			Jackson/W	ife	Took D		9 Hillmea	de Stat						0720 own, State
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Bany injury or other traumatic event, the Medical Examiner must be notified at once.			☐ Cremation 3 ☐ Re	emoval from State	Ce	emetery, crer	natory or other place coln Ceme		Date				-	
nit. Pa artme oortan injury			5 Other (Specify) neral Service Licensee	1	roi		2. Name and Addre							
Imp Dep any		> Yout	Charle	com			217 9th S					200	11	
Physician/		23a. Fart 1. Enter t shock, or hea Immediate Cause (disease or condition		cause on each line) .		er the mode of dyin		iac or res	spiratory arr	est,			Approximate Interval Between Onset and Death 1 year
Medical Examiner		resulting in death)	a.	Due to (or as a										
_xamme.	ier	Sequentially list co if any, leading to in	onditions, b.	Due to (or as	a consequ	ence of):						-	-	
d ansit	amir	cause. Enter Underlying Cause (Disease or liniplry that initiated events C.												
cate be executed physician and sthe burial-transit	J Ex	resulting in death)	Last	Due to (or as	a consequ	ence of):								
ate be physic the bu	edical		d.											
eath certifica attending p	n/M	IF FEMALE: 23b. Was decedent	pregnant 23	c. If yes, outcome			Tectorio programa	~~				23d. Dat	te of deliv	ery
The Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Out the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans.	Physician/M	1								nth	Day Year			
ires that the signed by do be detail	by Pl	Part II. Other signi	ficant conditions cont	ributing to death b	ut not res	ulting in the	underlying cause gi	ven in Part I.						he cause of death?
requires been sig should b									- [bably 4 XUnknown
law re has be e 2 sh	Completed								-	24a. Was autor perfo	osv		orior to co	ppsy findings available ompletion of cause of
sician: The law r certificate has k irector, page 2 s		25. Was case referr	red to medical				26 P	lace of Death (C	heck on	perfo 1 Yes	2 🔼 N	0	1 🗌 Yes	2 XNo
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ttendi death. :tor: A / the fu	Certificate:	2 Accident 3 Suicide	Investigation 6 Could not be	28e Place of Init	ury - At ho	me farm st	M 1 L	Yes 2 No	28f.	Location (S	Street an	nd Numbe	er or Rura	l Route Number,
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the Hospital or Attency in 24 hours after deatling the Funeral Director. The Funeral Director.	Medical	(Chook '	Certifying Physic Medical Examine Certifying Nurse	r On the basis of e	examination	and/or inves	stigation, in my opini	on, death occurr	ed at the	time, date a	and place	e, and du	e to the ca	ause(s) and manner stated.
	2	29b. Signature and	title of certifier				29c. Licens					ate signe	d (Month,	Day, Year)
6+1) 6			thia M					032				1	.0/03	/2011
			ress of person who cor a M. Willia				Print) St. NW	Washir	ngto	n,DC	2001	.6		
Sta	te	31. Date filed (Mon	th, Day, Year)	3. Registr					.0.55	.,				
Registra	ar	Of.	T 06 2011	Versus	, A	. 19 4								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Jones Physician/ Ruth Mae Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Cumberland Allegany Western MD Regional Medical Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs, last birthdav) **Funeral** Hours 0372771940 215-58-6410 1 🗆 M 2 🗓 F 71 Marvland Director Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location the Maryland Director 1 Yes 2 XNo MD Allegany Cumber land 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 21502 USA permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic 11400 Brown Hill Road, NE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 Yes 2 No Specify Specify 3 ☑ Widowed 4 ☐ Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Home 9 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wright Hook Emma Mae ೭ James Isaac 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12510 Woodcock Hollow Road, Mt. Savage, MD 21545 John J. Jones / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Sunset Memorial Park 1 X Burial 2 Cremation 3 Removal from State 10/07/2011 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. Signatur of Funeral Service Licenses 404 Decatur Street, Cumberland, MD 21502 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Provician/ dayl disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ Unknown g 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed his certificate hil director, page 1 Yes 2 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Be Hospital Other: မ 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural injury 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director; A

completed filled in by the 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 📆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 70131 2011

State

Registrar
DHMH 17 Rev 7/2009

Willow Brook Road Cumberland MD-21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 201

12500

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33628 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bernice E. Jackson 0020 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Western MD Regional Medical Center Allegany Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 Director 215-24-7995 81 October 14, 1929 Maryland Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** must be notified Maryland Allegany Frostburg 1 X Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Frost Avenue 23a 21532-U.S.A. ural", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No þ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes. Give Completed 3 ☐ Widowed 4 ☐ Divorced Specify: Year or Dates Black traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) filed within 72 at Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, marked မ Joseph Coates Susan Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .8 Health tem 27 Leonard Jackson, Sr. husband 15 Frost Avenue 21532-Maryland Frostburg 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or of cemetery, crematory or other place) ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory October 01, 2011 Cumberland Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 wholas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner neumonia backria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant g Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has autopsy performed Physician; Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 💢 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Watural iniury 5 Pending work? within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 091 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Denise K. B. Hwer CRN 12500

Registrar DHMH 17 Rev 7/2009

State

Denise K. Bitther

OCT

04

31. Date filed (Month, Day, Year)

MOW BROOK

21509

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 10 Physician/ JOHNSON 1:18 P M DAVID 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PG CRESCENT CITIES RIVERDALE GENESIS If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🙀 M 2 🗆 F 10/23/1969 Virginia Director 577-98-7129 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 X Yes 2 ☐ No Upper Marlboro Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20774 USA 9713 Summit Circle #3B Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 1 K Yes 2 □ No If Yes, Give 1 Q Baltimore, Maryland 21215-0036 res, Give Year or Dates. 1987–89 1 ☐ Yes 2 K No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Alexandria City Gov't Auto Mechanic 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Jacqueline Bailey Phillip Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 9713 Summit Circle #3B Upper Marlboro, Md Tracy Johnson / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State Fort Lincoln Crematory 10/11/11 4 Donation 5 Other (Specify) Brentwood, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fort Lincoln Funeral 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Brentwood, Md 20722 Approximate Interval Between Onset and Death Immediate Cause (Final Physician NEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ Unknown After this certificate has been signed by the functional director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SARCOMA 4 Unknown 1 Yes 2 No 3 Probably ACQUIRED IMMUNO DEFICIENCY SYNDROME 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Sursing Home 5 Residence 6 Other (Specify) 잍 within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 28a. Date of injury 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work 1 Yes 2 No M 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Mursy Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Morth, Day, Year) 29b. Signature and title of certifi 29c. License number completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

Registrar
DHMH 17 Rev 7/2009

State

EAST

WEST

4409

32. Regis rar's Signature

HUSAIN

11-06827 Leon Johnson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

on Johnson	1- For State Certificate of Death Reg. No.												
Physicia	an/	Decedent's Name (First, Midd)	e,Last)						1	. Date of Deat	n Dav Year	3	3. Time of Death 2239 hrs
dical Exami	ner	Leon A. John			1 41	. City, Tox	en or le	eation of		Septembe	r 9, 2011 4c. County of	Death	2239 NIS
		4a. Facility Name (if not institution 7555 Waterloo Road	n, give street and n	umber)	44	Jessup	VII, OI LC	Cation on	Dealli		Howard	Boutin	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under	24Hrs.	8. Date of Birt	h(MM/DD/YYYY)	9. Birth	place (State or
Director		220-84-7342	1 X M 2 F		41 Yrs.	Months	Days	Hours	Min.	Nov 5		Foreign May	±y)land
	ŀ	Usual Residence of Decedent	44 (10.1 Levido Citatienio
w any		10a. State 10b, County	<i>(</i> -		, Town or Locatio							- 1	10d. Inside City Limits 1 Yes 2 X No
Maryland 28a-f shuw 1 at once.	힏	Maryland N/	A	B	altimor	10f. Zip C	odo		_	110	g. Citizen of Wha		
th the Maryland 23n nr 28n-f shn notified at once.	Director	10e. Street and Number					2122	2			USA	. Oodina	.,,
ith the		317 S. Fulto		cedent Ever in U	I.S. 13. Was				n? (Spe	cify Yes or No-		Americ	an Indian, Black,
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Was Decedent Ever in U.S. 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)								White,	etc.				
ufter d	The state of Divorced If Yes, Give Year of Dates: Specify: Sp										ack		
ours a	ed by	15, Decedent's Education (Spe	cify only highest gra		16a. Decedent's during mos						16b. Kind of Busi	ness/In	dustry
1215-0036 Id be filed within 72 hours at fental Hygiene. arked nither than "natural event, the Medical Examin	Completed	Elementary/Secondary (0-12) 8th	College (1-4 or 5+)	S	tude	ent				None	3	
215-0036 be filed within 7 ntal Hygiene. rked nther than ent, the Medica	E O	17. Father's Name (First, Middle			<u> </u>	-		.Mother's	Name (First, Middle, N	Maiden Surname)		
215 be file ntal Hy cked n	Be	James Johnso	n			-223-				a M. N			
ID 21: should! and Mer 77 is maric even													
e, MD 2 1 and 2 shoul Health and N item 27 is n r traumatic		Roberta M. Jo 20a. Method of Disposition	onnson (M							Date DZ	20c. Location - C	LIS City or T	own, State
Ore ges 1 a rof He ther t	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Metro Crematory 9-28-11 Baltimo.										nor	e, Md.	
it. Pagirthment	20a. Method of Disposition Burial 2 Accommation 3 Removal from State Metro Crematory 9-28-11 Baltimore Metro Crematory 9-28-11 Baltimore Crematory Policy Crematory Policy Crematory Policy Crematory Cre												
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√Wedica! ≟xaminer		Immediate Cause (Final disease	A										Death
		or condition resulting in death)	Due to (or as b. Hanging	a consequence	of):								
	er	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence	of):								
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uted nd ransit	EX	events resulting in death) Last	d		<u> </u>					-			
oe executed ician and irial - transit	dical	UNPENDED	AMENDED										
tox 68760, eath certificate be attending physic for use as the bur	S	IF FEMALE: 23b. Was decedent pregnant in t		, outcome of pre		al ale ath	3 [Ectopic	nrennan	ICV	23d. Date of d Month	elivery Da	av Year
certif	cian	past 12 months?	I L LIVE	birth jnant at time of d		al death er <i>(Specif</i>			program	Cy	Mornin		.,
Box 68760 e death certificate be the attending physied for use as the bu	hysi		known 9 Unk	and the state of t						1		4- 4- 4	
Division of Vital Records, P.O. Box 68760, To the Hoptial or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	by P	Part II. Other significant condi	tions contributing	to death but not	resulting in the ur	iderlying d	ause giv	en in Pari	t 1.		s 2 V No 3		ne cause of death?
ls, P.C. quires that en signed l										24a. Was			opsy findings available
ord aw rec has bec 2 shou	ple	· ———							_		rm <u>ed</u> ? de	eath?	ompletion of cause of
Rec The I	Completed					200	Diana	of Death (Charles	1 Yes	2 No 1	✓ Yes	8 2 No
ital ician: s certi irector	Be	25. Was case referred to medical examiner?	Hospital:	Inpatient 2	ER/Outpatient		10	thor -			Residence 6	Other:	Scene
Division of Vital Records, tal or Attending Physician: The law requiremand of the form of the form of the formeral director, page 2 should be in by the funeral director, page 2 should be in by the funeral director, page 2 should be in by the funeral director, page 2 should be in by the funeral director.	<u>۲</u>	1 Yes 2 No 27. Manner of Death	28a. Dat	e of Injury	28b. Time of In	jury 28	c. Injury	at Work?		28d. Describe Subject han	how injury occurre	d	
ion tendin eath. or: A	ation		Con O	th, Day,Year) D: 2011_	FOUND: 2155 hrs		1 Ye	es 2 🗸 I	No				
ivisi or Att after d Direct	Subject hanged self The color of the colo											al Route Number, City	
D sspital hours neral filled	4 Homicide determined (Specify) Jail/Penal 7555 Waterloo Road, Jessup, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											d	
To the Hos within 24 h To the Fun completely	Medical	(Check only 1 Certifying Fone) 2 Medical Ex	aminer: On the basi	s of examination	and/or investigati	on, in my o	me, dad opinion,	death occ	urred at	the time, date	and place, and du	e to the	e cause(s)
To You	Med	29b. Signature and title of certif	and manner	stated.			License				29d. Date signe		
		Allen Be	asself, M	(H)			O.C.N	1.E.			September	10, 20	011
1 1		30. Name and address of perso							. 141	- ND 040	22		
41		Melissa Brassell, MD		ledical Exam			ore St	reet, Ba	utimor	e, MD 2122	<u> </u>		
S	tate	007 () (2011	egistrar's Signa	d. Da	New?							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Men Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Apt.# C2 Oxon Hill 570 Wilson Bridge Dr., If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday) 5. Social Security Numbe **Funeral** 1 □ M 2 🔀 F Months Days Hours Min 67 223-60-8591 1944 Director July Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director 1[™] Yes 2 □ No 28a-f Oxon Hill Prince George's MD 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a United States 20745 570 Wilson Bridge Dr., Apt. #C2 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ō 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 'natural", 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Private 12th Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ္ Edith I. Jones David Howard Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trains Delores A. Holmes/Sister 570 Wilson Bridge Dr, #C2, Oxon Hill, MD 20745 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place. Heritage Cemetery 10/8/2011 Waldorf, Maryland permit. Pope Funeral Homes, P.A. Signature of Funeral Service Licensee 22. Name and Address of Facility M009 Charles 5538 Marlboro Pike, Forestville, MD 20746 23a. Part 1. Enter the disease, or complications that caused and death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to jor as a consequence of burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Descript at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year ed by the a detached f 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown the Funeral Director, After this certificate has been significate has been significate has been significate has been significate has been significated. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Yes 2 1 Yes 2 No 25. Was case referred to examiner? 26. Place of Death (Check only one) Be Hospital: ပ္ 1 \sum Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 L Natural injury 5 Pending work? 1 Yes 2 No М Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical

within To the DHMH 17 Rev 7/2009

State Registrar

29a. Certifier

ne and address of person who completed cause of death (Item

29b. Signature and title of cert

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner:

The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 33632 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Irene W. Keene 2011 October 9:23 A^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Yea Hours 85 **Director** 579-20-9914 1926 March Florida Usual Residence of Decedent 28a-f show 10b County 10a. State with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits DC Washington 1 X Yes 2 No or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5229 Chillum Place, NE 20011 USA items death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 9 Completed by 1 Never Married 2 Married be filed within 72 hours after Yes 2 X No Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 😿 No Specify: "natural", 3 X Widowed 4 Divorced Specify: Black Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Mental Hygiene. arked other than life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Management Analyst Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked ည Henry J. Wiggins, Jr. Ruby Elizabeth Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Hosie Ward / Son 1243 Gallatin St., NE other Washington, DC Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 10/11/11 Brentwood, Md 21. Signature of Funeral Service Licensee

22. Name and Address of Facility Fort Lincoln
3401 Bladensburg Rd Brentw

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd Brentwood, Md. Approximate Interval Between Immediate Cause (Final Onset and Death Ph. sician/ disease or condition Acidosis Medical resulting in death) Due to (or as a consequence of): Examiner Septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami executed Multiple Myeloma and tran resulting in death) Last Due to (or as a consequence of) physician the burial burial Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🕱 No Pregnant at time of death Month Day 1 ☐ Yes ∠ ↓ 9 ☐ Unknown the s been signed by t ? should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anemia Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available 24a. Was an or Attending Physician: The law has autopsy perform prior to completion of cause of death?

1 Yes 2 No Yes 2 X No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 1 🔲 Yes 2 X No |6 1 X Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending s after death.

I Director: Af Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Hospital 24 hours Medical 29a, Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Pwithin 24 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D66249 October 5, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr.Jonathan Duran 1500 Forest Glen Rd., Silver Spring, Md

DHMH 17 Rev 7/2009

Registrar

BCT 1 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar 33633 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jean Dolores Miller Kunkle October 0 \mathbf{P}^{M} 2011 9:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Golden Living Center - Frederick Frederick Frederick If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Hours Min 217-12-1707 Director 1 M 2 X F 86 October 2, 1925 Maryland Usual Residence of Deceden 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director notified Maryland 1 X Yes 2 No Frederick Frederick 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? be must be 715 Midway Drive 21701 United States of America items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Black White etc. , or by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify. White d other than "natural", event, the Medical Exa Completed 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 12 Banking Loan Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clark A. Miller Beatrice V. Stotelmyer traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ted Mercer / Friend of Health 27 1509 Homestead Avenue, Frederick, Maryland 21702 Department of Health Important: If item 27 any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of October 20, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 2011 Signature of Funeral Service 22. Name and Address of Facility **Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701** M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. Examine Due to lot as a consequence on if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After iniury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one of certific 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number 30. Name and address of person who co pleted cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Kennev Jane Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany WMHS-RMC Cumberland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 - M 2 - XF Days Hours Min. ^{Ye}f 931 Aug°5, 215-26-9468 **Director** 80 Usual Residence of Decedent 28a-f show should be filed within 72 hours after death with the Maryland nand Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director MD Allegany Frostburg 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 59 Ormand Street 21532 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 🗆 Yes 2 🗖 No Baltimore, Maryland 21215-0036 Specify: 3 XWidowed 4 ☐ Divorced Specify: white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Morgan Dilmond James 19a. Informant's Name/Relationship (Type, Print)
Bernard Kenney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 59 Ormand Street Frostburg MD 21532 son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Tremation 3 Removal from State Scarpelli Funeral Home, P.A. 10/13/20 MD Cresaptown nation 5 Othe (Specify) 22. Name an Scaling Fullieral Home, PA 21. Signature o Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Intarctim Myocardia disease or condition Medical resulting in death) Examiner voratory. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signed I should be det 23e. Did tobacco use contribute to the cause of death? Completed by resp. failure Records, 2 No 3 Probably 4 Unknown 1 Yes coronary Artery disease 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has autopsy performed page 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year)
28b. Time of injury
(injury)
28c. Certificate: Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 Yes 2 No Investigation Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Example 2 Tertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year) RN 164718 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12501 Willawbrook Rd. Cumberland, MD State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	_ State	te of Maryland		rtment of F tificate of D			giene Reg. No. 201	1 33635
		1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
Physician Medica		Mary Anna Kno	otts				Septem	ber 24 20	
Examine	er '	4a. Facility Name (if not institution, give street and Memorial Hospita)	d number)		4b. City, Town, or East	Location of Death		4c. County of Di Talb	ot
Funeral Director		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt 12/71/3/2		Birthplace (State or Foreign Country) DE
- A	. h	Usual Residence of Decedent 10a. State 10b. County	10c City I	Town or Loc	eation				10d. Inside City Limits
Aaryland 8a-f sh tified a	recto	MD Caroline	Dent						1 ☐ Yes 2X No
th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Number 26259 Anthony Mill R	oad		10f. Zip Code 21	529		10g. Citizen of What	Country?
or ite	ρ	1 Never Married 2 Married 1 If M	s Decedent Ever in U.S. ned Forces? Yes 2 XNo es, Give r or Dates.	If	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Specify. Whi	
1215-0 hin 72 hou ne. than "natu	Completed	15. Decedent's Education (Specify only highest grade complete (Specify only highest grade Complete (12) Col		(Give I life. D	lent's Usual Occup kind of work done O NOT use retired) omemaker	ation during most of wor	king	16b. Kind of Busine Family	ess Industry
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygientment of Health and Mental Hygientment of Health and Mental Hygientment of Health and St is marked other than "natural", o any injury or other traumatic event, the Medical Examologe.	as b	17. Father's Name (First, Middle, Last) Norman Lewis Forak	er			18. Mother's Nar Dorotl	ne (First, Middle, ny Mary	Maiden Surname) Butler	
Maryl d 2 should alth and Me 127 is mar		19a. Informant's Name/Relationship (Type, Prin Paul P. Knotts / Hu		19b. Mailir 2625	ng Address (Street 9 Anthon	and Number or Ru y Mill Ro	ral Route Numbe	er, City or Town, State con, MD 216	, Zip Code) 529
Baltimore, sermit. Page 1 and Department of Hea mportant: If item any injury or othe page.		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	al from State cen	netery, cren	sition (Name of natory or other pla rematory	o9/2	Date 25/2011	20c. Location - City Dover, DI	
Balti permit. Departi Importa any inji			ook	Мо		1 Home, P.A			on, MD 21629
Physician/		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Immediate Cause (Final disease or condition	s that caused the death. e on each line.	Do not ente	er the mode of dyi	ng, such as cardiad	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (Was a conseque	nce of):					
7 =	niner	nasses Enter Underlying	Due to (or as a conseque	nce of):					
be executed sician and burial-transit	al Examiner	Cause (Disease or linjury that initiated events c c lesselfing in death) Last	Due to (or as a conseque	nce of):					
760 cate be ex physician s the buria	ledical	d							
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. To the Funeral Director: Affect his certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	in the past 12 months?	res, outcome of pregnand Live Birth 2 Fetal Pregnant at time of de Unknown	death 3 L	Ectopic pregnar Other (specify)	ncy		23d. Date o Month	
S, P.O. Bornes that the designed by the signed by the added by the signed by the signe	d by Phy	Part II. Other significant conditions contribute	ng to death but not resul	Iting in the (underlying cause g	iven in Part I.			te to the cause of death?
Division of Vital Records, all or Attending Physician: The law requires is after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be	omplete			-			24a. Was auto perf 1 \subsection Yes	opsy formed? prio	re autopsy findings available ir to completion of cause of th? Yes 2 \(\sime\) No
al Hisan: The strifficat ctor, pz	Be C	25. Was case referred to medical examiner?				Place of Death (Che	eck only one)		
of Vital Rec 9 Physician: The lav pr this certificate has eral director, page 2	မ	1 Ves 2 No	1 Minpatient 2 L E	R/Outpatie 28b. Time o injury	f 28c. Inju	iry at		how injury occurred	Specify)
Division of To the Hospital or Attending F within 24 hours affer death. To the Funeral Director: After completed filled in by the funer.	Medical Certificate:	1-2 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	e. Place of Injury - At hon building, etc. (Specify)			Yes 2 No	28f. Location	(Street and Number o	or Rural Route Number,
Div oital or urs afte ral Dir	alCe	29a. Certifier 1 Certifying Physician:		dee dooth	assured at the time	on data and place	4		as stated.
ne Hosp in 24 ho ne Fune pleted f	Medic	(Check 2 Medical Examiner: Or only one) 3 Certifying Nurse Prac	the basis of examination tioner: To the best of my	and/or inve: knowledge,	stigation, in my opir death occurred at	nion, death occurred the time, date and p	d at the time, date blace, and due to t	the cause(s) and mann	er as stated.
To ti with To ti		29b. Signature and title of certifier	N Si	MACEN	29c. Licen	o 4584		29d. Date signed (A	Month, Day, Year)
		30. Name and address of person who complet JEAN GATUEY 31. Date filed (Month, Day, Year)	red cause of death (Item)	23a) (Type,	Print) Imans L	ANE LEA	-570N, n	0 21601	
Sta Registr	te ar_	31. Date filed (Month, Day, Year) 7 2011	32. Fegistrar's Signatu	ire .	bank				

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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Thelma Eleanor Long October 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Devlin Manor Health Care Center Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Days 1 - M 2 - XF Hours Min 09/21/919 92 120-18-7685 Pennsylvania **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10d. Inside City Limits must be notified at 10c. City, Town or Location Directo MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 9 10f, Zip Code 10g. Citizen of What Country? Funeral USA , or items 23a 135 N. Mechanic Street 21502 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No the Medical Examiner Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes Give "natural", 3 Widowed 4 X Divorced Specify: Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. within 72 life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Estella Long (unknown) Blank and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19304 Upper Consol Rd, NW, Frostburg, MD 21532 LeRoy F. Witt, Sr. / Brother permit. Page 1 and 2 Department of Healtl Important: If item 2 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Cumberland Crematory 10/06/2011 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig lature of Funeral Service proenses 22. Name and Address of Facility Adams Family Funeral Home, P.A. any 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter-the dise Part 1. Enter-the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition don seumo Medical resulting in death) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Examine Due to (or as a nonsequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No for Month Year 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ þe 1 🗌 Yes 2 →No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? death? within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 1 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 | No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis or examination allows investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of c 29c. License number 29d. Date signed (Month, Day, Year)

ング State

DHMH 17 Rev 7/2009

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Registrar

31. Date filed (V riti , 4 ay, Fear)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Anthony J. Bollino, M.D.,

D17565

922 National Highway, LaVale, MD

October 5, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** 2011 OCTOBER 14 VIRGINIA MARIE 11:45 p[™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Hospital Center Chestertown Kent If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 27 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Year)} 1924 Days 1 □ M 2 F Maryland 218-48-5131 87 Director Usual Residence of Decedent with the Maryland fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 72 Is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, its Marginal Engillant man to another at Director 1 ☐ Yes 2 🔀 No MD Queen Anne's Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 126 Hatchett Rd. 21617 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White Specify: <u></u> 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Cook Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George E. Stubbs Lula E. Tate 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Ervin (daughter) Centreville, MD. 21617 217 Coon Box Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesterfield Cemetery 10/18/11 Centreville, MD. 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Sc
118 West Cross St. Galena, MD. 21635 21. Sign Ture of Ful мб0510 art 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final disease or ition resulting in eath) **Physician** FAILURE CONGESTIVE 10 years /Medical Due to (or as a consequence of) Examiner HYPERTENSION ULMONARY Gequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death signed by the a P.0. □Yes 2X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 **X**No 1 □Yes 2 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient ပ 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 28c. Injury at Work? al or Attending F s after death. Il Director: After ed in by the funer Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00041587 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

State

Chestertown, MD. 21620

122 Speer Rd.

Registrar's Signatur

32.

Helen A. Noble, M.D.

OCT 21

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 33638 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September Physician/ 2011 11:47 AM Paul Daniel Lowman, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Manor Care Nursing Home Largo Birthplace (State or Foreign Country) Social Security Number If Under 1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral Hours Months 144-24-0843 **Director** 1 XM 2 □ F Sept. 26, 1931New Jersey 80 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director 1 X Yes 2 No Maryland Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number must be Funeral 23a USA 20720 12403 Shafer Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11 Marital Status "natural", or iter Armed Forces Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give 1953 Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Nasa Goddard Space al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Flight Center Geologist traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F ည Marion Sydney Pemberton Paul Daniel Lowman, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a 12403 Shafer Lane Bowie, MD 20720 Karen-M.A. Lowman/ Wife other. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Injury or Department of Important: If any injury or 4 Donation 5 Other (Specify) 10/5/2011 Crownsville, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Transitional Cell Carcinoma of the Bladder disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner District as a consequence of Cause (Disease or injury that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś Chronic Kidney Disease 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Medical Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Metastatic Brain Cancer page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? 1 \(\text{Yes} \) 2 \(\text{X} \) No 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred ywithin 24 hours after death.

To the Funeral Director: After t 1 X Natural 5 Pending iniury Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Physician: 29a. Certifier In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated efficiency. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Or Certifying Nurse Place (Check only one) 29b. Signature and title 2 2011 20 completed cause of death (Item 23a) (Type, Print) 2+1

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month

			_ State	laryland / Depa	artment of He			2111	1 33639
			Registrar 1. Decedent's Name (First, Middle, Last)		incate of be	atti	2. Date of Deat	th	3. Time of Death
	Physicia		Gertrude W. Lord				Month		Year
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo	ocation of Death	OCC.	4c. County o	
	LAUGHI		210 Bernard Avenue		Federal	sburg		Caro	oline
	Funeral			ge (In yrs. last birthday)	If Under 1 Year In	f Under 24 Hrs. Hours Min.	8. Date of Birth		Birthplace (State or Foreign Country)
	Director		216-05-3055 ¹□м²¼F	93 Yrs.	Wichario Days	10010	(Month, Day,	1918	Country) Maryland
	nd now at	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	arylar a-fsl fied	Director	MD Caroline		Federals	sburg			1 XYes 2 ☐ No
	or 28	흅	10e. Street and Number		10f. Zip Code			10g. Citizen of WI	hat Country?
	with 1	Funeral	210 Bernard Avenue		2163	32		United	States
	leath items ier m		11. Marital Status 12. Was Decedent Armed Forces?		Was Decedent of Hispa f Yes, specify Cuban, I				- American Indian, , White, etc.
36	after (I", or kamir	l by	1 Never Married 2 Married 1 Yes 2 If Yes, Give		1 ☐ Yes 2 👿 No			Specify:	White
8	atura cal E	Completed	3 X Widowed 4 Divorced Year or Dates.	16a Decer	dent's Usual Occupation	on		16b. Kind of Bus	
215	an "n Medi	ldm	(Specify only highest grade completed)	(Give	kind of work done duri O NOT use retired)	ing most of worki	ing		
212	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho ; the Medical Examiner must be notified at	ပိ	Elementary/Seconday (0-12) College (1-4 or		stress			Sport	swear
p	be filed ental Hy- rked oth ic event	Be	17. Father's Name (First, Middle, Last)		18		,	Maiden Surname)	
yla	should be file n and Mental I 7 is marked o raumatic eve	잍	Joseph Waldis				.e Scot		
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) Philip L. Lord, Jr.	ndson 19b. Mailir	ng Address (Street and Dublin Hi				
e,	and Healt Healt tem 2		20a. Method of Disposition	20b. Place of Dispo			Date	-	City or Town, State
nor	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		natory or other place)	10/1			sburg, Maryland
į			21. Signature of Funeral Service Licensee		2. Name and Address				
ñ	Dep Imp		Michael 7- Estern	ederalsb	ourq, MD	21632			
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lif	ed the death. Do not ente	er the mode of dying, s	such as cardiac o	or respiratory arre	est,	Approximate Interval Between
			Immediate Cause (Final disease or condition	b/n Ans.	st				Onset and Death
			resulting in death) Due to (or as	a consequence of):	· .				1
	Medical Examiner	er	Sequentially list conditions, b. Due of or se	hon me	wana				wee bs
	ed rsit	Sequentially list conditions, if any, leading to immediate	cause. Enter Underlying Cause (Disease or iinjury	ash 6			1445		
	xecut n and al-tra	Еха		a consequence of):					7
09	e be e ysicia	lical	d						
876	tificat ng ph as th	Mec	IF FEMALE:	·-					
Box 687	th cer tendi	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live Birth	2 Fetal death 3	Ectopic pregnancy			23d. Date Mon	e of delivery th Day Year
Bo	e deal the at hed fo	Physician/Me	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant 9 ☐ Unknown 9 ☐ Unknown		Other (specify)			Wion	Day Tour
P.O.	at the		Part II. Other significant conditions contributing to death	but not resulting in the u	underlying cause given	in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
S, F	ires the signer of the signer	Completed by	Colonary Atry Dis	eux			1 🗆 ነ	res 2 No	3 ☐ Probably 4 ☐ Unknown
ord	requ been shoul	lete					24a. Was a	an 24b. W	/ere autopsy findings available
ec	ne lav e has age 2	l lil						rmed? d	rior to completion of cause of eath?
E H	an: The tifficat tor, po	Be C	25. Was case referred to medical		26. Place	e of Death (Chec	1 Yes	Z LJ NO	Lifes ZEINO
Vit.	hysician: The law requires that the death certifical his certificate has been signed by the attending platiector, page 2 should be detached for use as t	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpa	tient 2 ER/Outpatie	nt 3 DOA Other:	4 Nursing Ho	ome 5 Resid	ence 6 Other	r (Specify)
of	ng Ph ter th neral		27. Many of Death 28a. Date of inj 1 Natural 5 Pending (Month, D.	jury 28b. Time o ay, Year) injury	f 28c. Injury a work?	t	28d. Describe h	ow injury occurre	d
ion	ttendir death. stor: Af , the fu	ifica	2 Accident Investigation		M 1 Ye	es 2 🗆 No			
Division of Vital Records,	or Att	Certificate:	28e. Place of In	ijury - At home, farm, str tc. <i>(</i> S <i>pecify)</i>	eet, factory, office		28f. Location (S City or Tow		r or Rural Route Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completed filled in by the		29a, Certifier 1 Certifying Physician: To the best of	of my knowledge, death	occured at the time. d	ate and place, ar	nd due to the car	use(s) and manne	r as stated.
	e Hos n 24 h e Fun	Medical	(Check 2 Medical Examiner: On the basis of only one) 3 Certifying Nurse Practioner: To the	examination and/or inves	tigation, in my opinion,	death occurred a	t the time, date a	nd place, and due	to the cause(s) and manner stated.
	Vithii vithii Comp	-	29b. Signature and title of certifier		29c. License n	umber			(Month, Day, Year)
			1.6.1- mo		OE CI	000816	07	10/1	3/2011
			30. Name and address of person who completed cause of	2 /	Print)	000811	04		
				looming aul	1 Fedu	alsbus	FA 211	032	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Regist	trar's Signature	and I				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ C. VINCENT MACRINA October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3 Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs Social Security Number Age (In vrs. last birthday 8. Date of Birth **Funeral** 2 1 👿 M 2 🗆 F Months Hours March 30,1929 010-22-9856 82 **Director** Usual Residence of Decedent 0 or 28a-f show at 10a. State 10b. County 10c. City, Town or Location Director 1106/4/01 the Medical Examiner must be notified Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 20878 10 Michele Court United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent Ever in 0.5.

Armed Forces?

1 ☑ Yes 2 ☐ No 1948—
If Yes, Give
Year or Dates. 1952 "natural", or þ 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 bepartment of Health and Mental Hygiene. Important: If feen 27 is marked other than "ne any injury or other traumatic event " once. (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Hewlett Packard Personnel Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Melina Lombardo Ralph Macrina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Michele Court, Gaithersburg, MD Carole T. Macrina (Spouse) Date 8, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Oct. 2011 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State Metropolitan Crem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lich see 22. Name and Address of Facility DeVol Funeral Home (M01116)23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Pheumonia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine and -transit The law requires that the death certificate be executed Due to (or as a consequence of resulting in death) Last physician a the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 the attending ploched for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death signed by the a 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Diabetes 24 hours after death.

• Funeral Director: After this certificate has been six leted filled in by the funeral director, page 2 should t 24a. Was an autopsy perform To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 욘 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: work?
1 Yes 2 No 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one 29b. Signature and title of certifier 29c. License, number 000 680 80 10+1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

Shireesha Jalli MD

OCT 0 6 2011

31. Date filed (Month,

Alexandria, VA 10 East Deer Park Dr. Gaithersburg, MD 20877 Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 No 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10/04/2011 Rockville, MD 9901 Medical Otr Dr 20850

33640

4:20 PM

1 ☐ Yes 2 🗓 No

9. Birthplace (State or Foreign

Massachusetts

2011 Year

4c. County of Death

Montgomery

14 Race - American Indian.

White

Black, White, etc.

Specify:

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-07640 State of Maryland / Department of Health and Mental Hygiene 33642 Lawrence W. Munday 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 12, 2011 1124 hrs **Medical Examiner** Lawrence W. Munday 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Gaithersburg 10221 Peanut Mill Drive If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreignWashington Months Days Hours 48 07/30/1963 Director 215-72-8926 1 ★ M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 No 01ney Maryland Montgomery 28a-f show permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 20832 4117 Shallow Brook Lane United States Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. 1981-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 No 1X Yes White 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year 1984 Specify 15. Decedent's Education (Specify only highest grade completed) ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ltimore, MD 21215-0036 12 0 Project Manager Communications 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Patricia Watkins Robert Willis Munday, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4117 Shallow Brook Lane, Olney, MD Laura M. Grieco/Friend 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State 10/15/11 Alexandria, VA Metropolitan Crem. 4 Donation 5 Other Specify) 22. Name and Address of Facility 21. Signature of Emperal Service Lixinsee Muriel H. Barber Funeral Home Laytonsville, Maryland P.O. Box 5038, Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Retween Onset and allure. List only one cause on each line Medical Death a Acute and chronic alcoholism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as, a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f, per me, g920 10-24-11 sm X UNPENDED signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 V Unknown Completed has been si 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? certificate h rector, page ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 Other Scene this 1 🗸 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death 1 Natural fd 10-12-11 fd 11:10 am subject ingested alcohol 1 Yes 2 X No death. Pending Director: d in by the f 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10221 Peanut Mill Dr. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Could not be Suicide residence filled determined (Specify) Gaithersburg, Md Homicide

within 24 hours after To the Funeral Dire

ca

29b. Signature and title of certifier

Russell Alexander MD. 31. Date filed (Morth, Day, Year)

Registrar

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated.

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

October 13, 2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea					ndelible Ink				Legible	э.
	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 0 3 3 6 4											1 3361.3	
		Registrar 1. Decedent's Name	(First, Middle	, Last)				itilicate of L)Galii	2. Date of Dea	ath		3. Time of Death
Physicia: Medic		Danie	1 Calv	in Misne	r					Octobe	r 3,	201 Jean	10:00 A M
Examin		4a. Facility Name (if						4b. City, Town, or		4c. County of Death			
<i>-</i>		13907 5. Social Security Nu		ederick 6. Sex			st birthday)	Rocky I	Ridge If Under 24 Hrs.	8. Date of Birt		rederi	Birthplace (State or Foreign
Funeral Director		220-54-44	22	1 M 2 □ F		60 (III yis. ia	Yrs.	Months Days	Hours Min.	9-30-1	95 ¹	0.0	Maryland
and show at	o	Usual Residence of 10a. State	Decedent 10b. County			10c. City	, Town or L	ocation					10d. Inside City Limits
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	MD.	Frede	rick		Ro	cky R						1 ☐ Yes 2 🔀 No
th the 3a or t be n		10e. Street and Nurr						10f. Zip Code			10g. Citizen of What Country? U.S.A.		
ath wi	Funeral	1.3907 11. Marital Status	Old F1	rederick			13	21778 Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-			merican Indian,
ter de , or ite	by	1 Never Marri	ed 2 🗓 Mar	ried 1 Type	. 2	No	- 1	If Yes, specify Cuba 1 ☐ Yes 2 🗷 No		Rican, etc.)		Black, Wh	
ours at	ted	3 Widowed				4 Apr		edent's Usual Occup					nite
72 hc	Completed		cify only highe	nt's Education est grade complete	d)		(Giv	edent's Usual Occupi e kind of work done o DO NOT use retired)	during most of work	ring	16b. Ki	ind of Busines	3S Industry
withir giene ier tha		Elementary/Seco	onday (0-12)	College	(1-4 or 5	(+)	Truc	k Driver			Tr	rucking	· -
e filed Ital Hy ed oth	To Be	17. Father's Name (F							18. Mother's Nam			Surname)	
d Men marke		John 1 19a. Informant's Na		Misner			10h Ma	ling Address (Street a		Mae Engl		Town State	Zin Code)
12 shouth an 27 is			Jean 1		life								, MD. 21778
1 and of Hee		20a. Method of Disp	osition				lace of Disp	position (Name of ematory or other place		Date			or Town, State
ment ment tant: I		4 Donation	5 Cremation	3 ☐ Removal fro Specify)	m State	1	thave	n Cemeter	y Oct.6	,2011		derick	
permit Depart Impor any in once.		21. Signature of For	peral Service I	icensee	>								Son F.H., P.A. ryland 21788
	Н	23a. Part 1. Enter the	he disease, or	complications that	it caused	the death	n. Do not er	nter the mode of dyin				ic, ilai	Approximate
Physician/		shock, or hear Immediate Cause (I disease or conditio	Final	only one cause on			WEL	OID LE	UKEMI	4			Interval Between
Medical Examiner		resulting in death)		a. Due t		a consequ							
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uted d ansit	Examiner	if any, leading to imcause. Enter Under Cause (Disease or that initiated events	iinjury	5									
executed ian and urial-transit		resulting in death) l	_ast	Due t	o (or as a	a consequ	ience of):						
ate be physic the bu	edica			d									
certific nding use as	n/M	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, c				□ 5 -1				23d. Date of	delivery
death he atte ed for	Physician/Medical	in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown			egnant a	t time of c		☐ Ectopic pregnand ☐ Other (specify)	Jy			Month	Day Year
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uires th	ed by							· -		1 🗆	Yes 2	≥ 40 3 □	Probably 4 Unknown
aw req as bee 2 shoi	Completed									24a. Was auto	psy	prior	autopsy findings available to completion of cause of
The lacate h										1 🗆 Yes	ormed?	death	Yes 2 No
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g Phy er this neral d	te: To	27. Manner of Death	1	28a. Da	te of inju	iry	28b. Time injury	of 28c. Injur	y at	28d. Describe I			recity)
tendin eath. or: Aft the fur	Certificate:	1	5 ☐ Pendi Invest 6 ☐ Could	gation				M 1 🗆	Yes 2 No				
lor At after d Direct	Cert	4 Homicide	detern	28e. Pla		ury - At ho c. (Specify		street, factory, office		28f. Location (S City or Tov			Rural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur	29a. Certifier (Check only one) 29a. The continuous physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												he cause(s) and manner stated.
To th within To th comp		29b. Signature and		110	N	, m	0	200 Licens	o number		20d Da	to signed /Mc	onth Day Vearl
10		30. Name and address	ess of person	who completed ca	ause of d	leath (Item	23a) (Type	, Print)	SEVENT	74 51.	H	ESEL	20/1 21/01/21/01
Stat		31. Date filed (Mont	h, Day, Year)	2011 32	Registra	ar's Signa	ture	ankel		,	-		
Registra	ar	U	101 00	LVII	A STATE	and the same of	po sug	200 an					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33644 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 22, 2011 Physician/ 11:54 PM Margaret Anne_McCormick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Center Cheverly If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Days Hours Min. (Month, Day, Year) 578-34-9244 Director 1 🗆 M 2 🗶 F 82 June 9, 1929 Pennsylvania Usual Residence of Decedent or 28a-f show 10b. County 10d. Inside City Limits 10a State 10c. City, Town or Location must be notified at **Funeral Director** 1 X Yes 2 No Maryland Prince George's Bowie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? items 23a USA 20715 3907 Croydon Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Was Deceden 2. Armed Forces?

1 ☐ Yes 2 ANo the Medical Examiner Black, White, etc. ò Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker To Be injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fishers is marked o James Everett Young Oda White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 183 Cross Point Drive Owings, MD 20736 Sandra L. Todd/ Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Maryland Veterans Cemetery 1 X Burial 2 Cremation 3 Removal from State 9/29/2011 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home Signature of Funeral Service bicense Jos= 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Cerebral Vascular Accident Medical resulting in death) Examiner Cerebral Contusion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Pedestrian Struck attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease 1 🗌 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifici 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 2 🗌 No 1 X Yes 1X☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month. Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural 2 X Accident 5 Pending 9/1/2011 2 **X** No Pedestrian Struck 2:06 Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Street 28f. Location (Street and Number of Rural Route Number City or Town, State) 6810 Race Track Rd Bowie, MD 20715 determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011

Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of M	1arylan					and Me	ental Hy	giene		1
		State Registrar	Cer	tificate	of L	eath			Reg. No	011	33645			
П	Physicia	n/	1. Decedent's Name (First, Middle, Last)							- 1	Date of Dea Month		Year	3, Time of Death
A 150	Medic		William Covington		1						Septemb		9. 2011	3:20 P ^M
	Examin	er	4a. Facility Name (if not institution, give s	treet and number)				Town, or rwoo	Location o	of Death			County of Death nne Aru	
	F1		506 Mitchell Road 5. Social Security Number 6. See	(T7 A	ne (In vrs. la	ast birthday)	If Under		If Under:	24 Hrs.	8. Date of Birt			place (State or Foreign
4	Funeral Director		239-09-0126	% M 2 □ F 7. A	96	Yrs.	Months	Days	Hours	Min.	(Month, Day 8/6/1		Nort	h Carolina
			Usual Residence of Decedent								5/ 5/ -			
	/land f sho ed at	햧	10a, State 10b. County		10c. Cit	y, Town or Lo							1	10d. Inside City Limits 1 ☐ Yes 2 🖁 No
	28a- potifie	je	Maryland Anne Aru	ndel		Harw	-,							
	th the	틸	10e. Street and Number				10f. Zip	2077	16			10g. Citiz	en of What Cou USA	intry?
	ms 2	Funeral Director	506 Mitchell Road	12. Was Decedent	Ever in LLS	2 113 1				gin? (Speci	fy Yes or No-	1.	4, Race - Ameri	oon Indian
(0	or ite	질	1 Never Married 2 Married	Armed Forces	No.	1	f Yes, speci	ify Cuba	n, Mexican	n, Puerto Ri	ican, etc.)	1,	Black, White,	
036	rsafte ral", Exar	Be	3 🏋 Widowed 4 □ Divorced	If Yes, Give Year or Dates.		1	I ☐ Yes 2	2 🚹 No	Specify:			S	pecify:	White
5-0	hou "natu dical	Bet	15. Decedent's Edi (Specify only highest grad			16a. Deced	dent's Usua	Occupa	ation	t of working	7	16b. Kin	d of Business Ir	ndustry
21215-0036	hin 7%	Completed by	Elementary/Seconday (0-12)	College (1-4 or	5+)	Ìife. D	O NOT use	retired)	•			Off	ice Equ	i nment
2	dwit Hygiei ther nt, th	Be C	17. Father's Name (First, Middle, Last)	l year		Se1f	гшрто	yea			First, Middle,			тршенс
Maryland	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	흔	Rufus Henderso	n Mitche	11				10. MOTHE		11a Co			
ary.	nd Me mark		19a. Informant's Name/Relationship (Typ			19b. Mailir	na Address	(Street a	and Numbe	er or Rural I	Route Numbe	r. Citv or Te	own, State, Zip	Code)
	d 2 sk alth a 27 is		Robert R. Mitchell	/ Son							ood, M			
ore,	of He of He fiter		20a. Method of Disposition 1 X Burial 2 Cremation 3 5	D		Place of Dispo	sition (Nam	ne of ther plac	e)	Da	nte	20c. Loc	cation - City or 1	Town, State
ш	Page 1 ment of l ant: If it ury or o	- 5	4 Donation 5 Other (Specify)	Hemovai Irom Stat)		. Linco	oln C	emet	ery				ntwood,	
Baltimore,	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tra once.		21 Signa ura 1 Fu, e. Hervice License	e		22	. Name and	d Addres	s of Facilit	y Geo	rge P.	Kala	ıs Funer	al Home
			yax re										water,	MD 21037
			23a/Part 1. Enter the disease, or complete shock, or heart failure. List only on Immediate Cause (Final	e cause on each li	ne.	#42.0P.V 13.1	0		g, such as	cardiac or	respiratory an	est,		Approximate Interval Between Onset and Death
	Physician Medical	9	disease or condition resulting in death)	a. Due to (or as	boira		tail	ure	*					
m.	Examiner			,	burrat		meu	mo	Ma					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as	s a consequ	uence oi).								
	outed nd ransit	(am	Cause (Disease or iinjury that initiated events	c										
	ite be executed hysician and the burial-transit	dical Examiner	resulting in death) Last	Due to (or as	s a consequ	uence of):								
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687	ertifica ding p	/We	IF FEMALE:	3c. If yes, outcom	e of pregna	ancv							Od Dato of doli	
Box	eath certificat attending ph for use as th	ciar	in the past 12 months?	1 Live Birth 4 Pregnant	2 Feta	al death 3	Ectopic p		ÿ			2.	3d. Date of deli Month	Day Year
Θ.	he de y the iched	Physician/Me	1	9 🗌 Unknown										
P.0.	es that the des signed by the a be detached i	by P	Part II. Other significant conditions con	ntributing to death	but not res	sulting in the u	ınderlying o	cause giv	en in Part	I.	23e. Did to	obacco us	e contribute to	the cause of death?
ds,	requires been sig should b	ed									1 🗆	Yes 2	No 3□Pr	obably 4 🗌 Unknown
of Vital Records,	law requi has been le 2 shoule	Completed									24a. Was		prior to c	opsy findings available ompletion of cause of
Re	The la	Con									1 Yes	rmed? 2 X No	death?	2 🗆 No
tal	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	lospital:				26. Pla		th (Check o				
Ţ	Physi this c	2	1 Yes 2 X No	1 Inpa		ER/Outpatier 28b. Time of		8c. Injury	4 ∐ Ni		ne 5 📉 Resid Bd. Describe h		Other (Speci	fy)
0 0	ding I th. After funer	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, D		injury	м	work		.	od. Describe i	iow injury	occurred	
Division	or Attending Physician; The law requires that the death certificate be executed bifter death. bifter death. certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 Suicide 6 Could not be	28e. Place of Ir	jury - At ho	me, farm, str	eet, factory	, office		2			Number or Run	al Route Number,
Οį	tal or Att			bullaing, e	tc. (Specify	<i>"</i>					City or Tou	/n, State)		
	To the Hospital of within 24 hours at To the Funeral D completed filled in	Medical	(Check 2 Medical Examin	cian: To the best of er: On the basis of	examinatio	n and/or inves	tigation, in r	my opinic	on, death od	ccurred at ti	he time, date a	and place, a	and due to the c	ause(s) and manner stated
	o the ithin 2 the o the orthe orthe	ğ	only one) 3 Certifying Nurse 29b. Signature and title of certifier A	Practioner: To th	e best of m	y knowledge,			e time, date number	e and place	, and due to th		and manner as	
	⊢ s ⊨ ō		Muslam A	elmane	~ a	enf		¥		6653	3			30, 2011
			30. Name and address of person who co		death (Item	n 23a) (Type, F	Print)					-		
H	r8.		213 Newpor		5ev	ernon	ray	k Y	n))	2114	6			
	Star Registra		31. Date filed (Month, Day, Year) OCT 0 3 20	32. Regist	trar's Signa	ture A. 4	barke	1						
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 29, 2011 12:00 P_M Lyle Jordan Millan Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 77 South Winchester Road Annapolis Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days 216-30-9097 Hours Min. 107171932 Maryland **Director** 78 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 77 South Winchester Road 21409 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 ♣No If Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White and 2 should be filed within 72 hours aft Health and Mental Hygiene. Iem 27 is marked other than "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the 5+ ${\tt Anesthesiologist}$ Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lyle Millan Sr. Eileen Doherty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Millan - Wife 77 South Winchester Rd, Annapolis, MD 21409 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State cemetery, crematory or other place)
Baltimore Crematory 1 Burial 2 Cremation 3 Removal from State 10/3/2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) any in 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Myclin ! 147 Duke of Gloucester St, Annapolis, MD 21401 -23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ an 240 disease or condition Medical resulting in death) as a consequency of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 E Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 3 Probably 4 Unknown 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{ Other (Specify)} Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 | Medical Examiner: On the basis of examination allows investigation, at my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State

Registrar

32. Pégistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

OCT 03 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2011

reda Murray	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.
Physician/ Medical Examine	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year October 4, 2011 3. Time of Death 1221 hrs
	4a. Facility Name (if not institution, give street and number) Easton Memorial Hospital 4b. City, Town, or Location of Death Easton Talbot
Funeral Director	5. Social Security Number 2 1 9 - 1 4 - 4 8 9 7 1 M 2 XF 8 5 Yrs. 6 Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 1 Under 1 Year If Under 24Hrs. 1 Min. 8 Date of Birth(MM/DD/YYYY) 9 Birthplace (State or Foreign Country) Maryland
id bow any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Preston 10d. Inside City Limits MD Caroline Preston
with the Maryland ms 23a or 28a-f show be notified at once. eral Director	10e. Street and Number 22403 Marsh Creek Road 10f. Zip Code 21655 United States
r death or ite	1 3 Y Widowod A Divorced III tes. Give test 1 Yes 2 XI NO Specify:
5-0036 led within 72 hours after litygiene. other than "natural", the Medical Examiner Completed by	
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umarite event, the Medical To Be Comple	Elbert R. Butler Lillie Adams
ore, MD 21 ss 1 and 2 should of Health and Me If item 27 is ma her traumatic ev	Martin Butler/Brotner 4/49 Harmony Rd., Fleston, Mb 2/039
Baltimore, MD 2121; permit. Pages I and 2 should be fil Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,	20a. Method of Disposition 1
ம் தித்திர் Physician	216 N. Main St., Federalsburg, MD 21632 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease or condition resulting in death) Between Onset and Death Death Due to (or as a consequence of):
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause c.
executed an and al-transit cal Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.
60, tre be execut hysician and e burial - tra	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
). Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transi Physician/Medical Ex	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (Specify) 9 Unknown
P. O. That deta	1 Yes 2 No 3 Probably 4 Unknown
cords, law requir has been s	24a. Was an autopsy prior to completion of cause of performed?
Vital Rec ynician: The land is certificate to director, page.	25. Was case referred to medical 26.Place of Death (Check only one)
ion of Vital I tending Physician: sath. or: After this certifi the funeral director, atton: To Be C	27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred
Division of Division of Papital or Attending Phours after death. Ineral Director: After to filled in by the funeral Certification: T	1 V Natural 5 Pending Investigation 2 Accident 2 Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Divisi the Hospital or Att hin 24 hours after do the Funeral Direct npletely filled in by sical Certifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital within 24 hours a To the Funeral I completely filled	1/98. USUNICIA I BE ARE TO BE A TOTAL TO A LANGE AND A MARKET AND A MA
	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) October 4, 2011
	30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
State Registra	and the second s

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exactions instituted to once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 - For State Registrar		Cert	tificate of l	Death		Reg	1. No2 0		33648
_	1. Decedent's Name (First, Middle, Last)						Date of Death Month	Day	Year	3. Time of Death
n al	Vivian Lee Morris						tober	2	2011	0380 AM
er	4a. Facility Name (If not institution, give street and			4b. City, Town, or		ath			ty of Death	
	16840 Henderson Road;		141464	Hende	rson If Under 24 H	re lo r	Data of Dinth	Ca	rolin	
	5. Social Security Number 222-28-4310 6. Sex 1 M 2 X F	7. Age (In yrs. last	Yrs.	Months Days	Hours Mi	n /	Date of Birth Month, Day, In. 13	1946	Cos	nplace (State or Foreign untry) Laware
	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation						10d. Inside City Limits
ector	Maryland Caroline	Hen	derson							1 ☐ Yes 2 🛣 No
ral Dir	10e. Street and Number 16840 Henderson Road;	lot 159		10f. Zip Code 21640				g. Citizen of USA	f What Co	untry?
Completed by Funeral Director	1 Never Married 2 Married 1 Yes.	ecedent Ever in U.S. Forces? s 2 X No Give r Dates:		/as Decedent of H Yes, specify Cuba □Yes 2 🛛 No	ispanic Origin? In, Mexican, Pu Specify:	(Specify erto Rica	Yes or No- n, etc.)		ack, White	rican Indian, , etc. hite
pletec	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College	ed) e (1-4or 5+)	(Give k	ent's Usual Occup ind of work done o O NOT use retired	durina most of w	vorking	16	6b. Kind of I	Business/I	ndustry
50	12		Seamst	ress			m	anufa	cturi	Lng
Be (17. Father's Name (First, Middle, Last)				18. Mother's N	lame (Fil	st, Middle, Ma	aiden Surna	ime)	
2	William J. Chambers				Ida Ma	e				
	19a. Informant's Name/Relationship (Type. Print) Leyton Lee Mitchell/	son		Address (Street) Chestnut				-		
	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal fro	m State i		ition (Name of atory or other place		Date				Town, State Maryland
	4 □ Donation 5 □ Other (Specify) 21. Signature of Fuperal Service Licensee	GIE	22.	Name and Address	ss of Facility					•
	Steph (FR	ughan	PC	eegle an Box 160	; Green	sbor	o, MD	21639	.Onc.	
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	resulting in death)			HYTHN	IIA					gare
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State Registrar

⋖. MCGLOTHIN, ANNIE

			•	Print in Black I				•	
		•	1 - State Registrar	of Maryland / Dep Cea	rtificate of Dea			i. No.2 ()	33649
	Physicia		1. Decedent's Name (First, Middle, Last) Annie Amelia McGlothir			1.1	Onto of Donth	Day Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and num MEMORIAL (HOSPITAL)		4b. City, Town, or Loca	tion of Death	PICINE	4c. County of Deat	h
بمجدد	Funeral		5. Social Security Number 6. Sex 1 M 2 M F	7. Age (In yrs. last birthday)		Inder 24 Hrs. 8. [Date of Birth	9. Bir	thplace (State or Foreign
_	Director ≥		218-34-9416 Usual Residence of Decedent	75 Yrs.	Wionthis Says Tros	09	9727719	935 Y	laryland
aryland	ia-f sho	ector	10a. State 10b. County Maryland Caroline	10c. City, Town or Lo	cation calsburg				10d. Inside City Limits 1 🙀 Yes 2 □ No
th the M	3a or 28 t be not	Funeral Director	10e. Street and Number	10001	10f. Zip Code		109	g. Citizen of What Co	ountry?
eath wi	tems 2 er mus	Fune		edent Ever in U.S. 13.	21632 Was Decedent of Hispani If Yes, specify Cuban, Me	ic Origin? (Specify	Yes or No-	U.S.A.	
s after d	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 Yes, Giv 3 Widowed 4 Divorced Fres, Giv Year or D	2 X No	If Yes, specify Cuban, Me 1 ☐ Yes 2 ▼No Spe		1, etc.)	Specify: White	e, etc. Thite
13-0030 72 hours after	"natur ledical l	Completed	15. Decedent's Education (Specify only highest grade completed	16a. Dece	dent's Usual Occupation kind of work done during	most of working	16	6b. Kind of Business	
within .	giene. Ier thar t, the M		Elementary/Seconday (0-12) College (1	-4 or 5+)	oo not use retired) emaker			Family	
ylarid Id be filed	ental Hy ked oth ic evemi	To Be	17. Father's Name (First, Middle, Last) Owen Lee Blockston			Mother's Name (First aomi Jest	, ,	den Surname)	
Viary	n and Mi		19a. Informant's Name/Relationship (Type, Print)	i i	ing Address (Street and No	umber or Rural Rou	ıte Number, Ci		
1 and 2	f Health item 27 other t		Kimberly Meadows/daughte	20b. Place of Dispo	Bailey's Store osition (Name of	Road, Fede		g. Maryland oc. Location - City or	
Dallillor Dermit, Page 1	tment o tant: If jury or		1 X Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	Denton Ce				enton, Ma	
bermi d	Depar Impor any in		21. Signature of Juneral Service Lice Se		2. Name and Address of F 2 South Sec			•	
, y			23a. Part 1. Enter the dispase, or complications that shock, or heart failure. List only one cause on each	caused the death. Do not ent ach line.	er the mode of dying, suc				Approximate Interval Between Onset and Death
	ysician/ Medical caminer		Immediate Cause (Final disease or condition resulting in death)	SEVERE (or as a consequence of):	COPD				YEARS
= = ;	cammer	Je.	Sequentially list conditions, lift any, leading to man addate cause. Enter Underlying	CRITICAL (or as a do requeste of):	AORTIC	STENOS	15		YEARS
executed	and transit	Examiner	Cause (Disease or iinjury that initiated events c.	(or as a consequence of):					-
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Sertificat	attending physician and for use as the burial-transit	n/Mec		tcome of pregnancy				23d. Date of de	livery
e death o	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	in the past 12 months?	nant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)			Month	Day Year
es that th	signed by I be deta	þ	Part II. Other significant conditions contributing to c	leath but not resulting in the	underlying cause given in	Part I.			the cause of death?
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n: The k	r this certificate has ral director, page 2	e Con	25. Was case referred to medical		26 Piggs of	f Death (Check only	performe	death?	s 2 No
VILA hysicia	his cert	To B	examiner? 1 Yes 2 146 Hospital: 1	inpatient 2 - ER/Outpatie	nt 3 DCA Other: 4 [ce 6 Other (Spec	cify)
nding P	ath. r: After t e funera	Certificate:	27. Manner of Death 1 Natural 5 Pending (Mon 2 Accident Investigation	of injury 28b. Time o th, Day, Year) injury	f 28c. Injury at work? M 1 □ Yes	_ 1	Describe how	injury occurred	
l or Atte	Directo			of Injury - At home, farm, str ng, etc. (Specify)	reet, factory, office		Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
Hospita	24 hours Funeral leted filler	Medical	29a. Certifier 1 Certifying Physician: To the barrier (Check 2 Medical Examiner: On the barrier only one) 3 Certifying Nurse Practioner:	sis of examination and/or inves	stigation, in my opinion, dea	ath occurred at the t	ime, date and p	place, and due to the	cause(s) and manner stated.
To the	To the	2	only one) 3 L Certifying Nurse Practioner: 29b. Signature and title of certifier Clause M. L.		29c. License num	ber	290	I. Date signed (Mont	h, Day, Year)
			30. Name and address of person who completed cause		Print)			eplember	25 2011
	Stat	e	31. Date filed (Month, Day, Year) 32. F		igton St	EASTON	CHA	21601	
	Registra		SEP 28 2011	por p. 4					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 17,19aper fh 10/11/11 Gertificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 30 Day Physician/ Month 09 2011 Hedrick E. Mitchell Jr. 11:15A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Southern Maryland Hospital Clinton Prince George's Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Country 1 XM 2 1 10/17/1958 Director 579-84-4866 52 Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No DC Washington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 4407 Payne Drive 20744 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black White etc. þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced Completed Black Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Specialist Federal Government event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Hedrick Eugene Mitchell. Sr. Shirley Gray and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other framone. Ε. Hedrick Eugene Mitchell. III 7th St. SE.#101, Washington, DC 20032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial 10/8/2011 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pope Funeral Homes, P.A. Signature of Funeral Service Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5538 Marlboro Pike, Forestville, MD 20746 Interval Between Immediate Cause (Final Onset and Death Physician/ Meterstains to lung lives Bone End Sty MELANOMA with disease or condition resulting in death) Unknow Medical Due to (or as a consequence of): Examiner PATHOLOGIL COMPRESSION FRACTURE OF SPINE Unknow Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown After this certificate has been signed by the a funeral director, page 2 should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 🔀 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of e Hospital or Attending Pl n 24 hours after death. e Funeral Director, After th Certificate: 28d. Describe how injury occurred iniury 1 X Natural 5 Pending Accident Investigation 6 🗌 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed 3 = within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signat

D43446

1 2150 Anapolis Road Suit 200 Glandle, Mo

10.2.11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death O'Neal Physician/ 2011 Elizabeth Marv 8:30 A M October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ällegany 408 Holland Street Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 ... M 2 ... F 067037 191 1 214-07-2076 100 Maryland **Director** Usual Residence of Decedent or 28a-f show 10a. State 10d. Inside City Limits 10c. City. Town or Location Examiner must be notified at Director MD Allegany Cumberland 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral USA 408 Holland Street 21502 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black White etc "natural", or þ 1 Never Married 2 Married ☐ Yes 2 🔀 No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: 3 X Widowed 4 Divorced Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Manager Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Harry Turley Sara Snelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Porter / Daughter 17203 Danmil Drive, Frostburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Sunset Memorial Park 10/08/2011 Cumberland, MD injury (4 ☐ Donation 5 ☐ Other (Specify) . Sun itun of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. Idans 404 Decatur Street, Cumberland, MD Sorer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1 Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physiciar Physician/Medical Records, P.O. Box 68760 as use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No been signed by the a should be detached f Yes the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 🗆 Yes 2 🗖 No Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be examiner? Other: 2 1 No 유 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29d. Date signed (Month, Day, Year) October 4, 2011 D0054004 nath (Nem 23a) (Type, Print) 1221-E National Highway, LaVale, Maryland

Registrar DHMH 17 Rev 7/2009

nxs

32. Registrar's Signature

who completed cause of deanna, M.D.,

Khanna,

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland /				lental Hyg	giene		
			State Registrar	Cer	tificate of D	eath		Reg. No	11	33652
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	Day	Year	3. Time of Death
	Medic	al	George Stuart Parker 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Lanatina of Dooth	Octobe:		JII ty of Death	6:40 A ^M
	Examin	er	8287 Haven Street		Dentor				oline	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bin	thday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birthp	place (State or Foreign
	Director		216-74-9192 ¹X□ M 2 □ F 68	Yrs.	Months Days	Hours Min.	09/23/	1943	Count	D.C.
	d tow	<u>.</u> ا	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Loc	cation		-		1	0d. Inside City Limits
	arylar a-f st fied a	scto								1 ☐ Yes 2 🔀 No
	cor 28 or 28 e noti	Ö	Maryland Caroline Dent	LOII	10f. Zip Code			10g. Citizen of	What Cour	ntry?
	with s 23a ust b	Funeral Director	8287 Haven Street		21629)		U.S	S.A.	
	death item		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)		ce - Americ	
36	after al", or xami	Completed by	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates	1	☐ Yes 2 Ϊ No	Specify:		Specif		ite
9	hours natura ical E	lete	15. Decedent's Education 16a		lent's Usual Occupa			16b. Kind of I		
215	e. Ban "r	duc	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give I life. D	kind of work done d O NOT use retired)	uring most of worki	ng			
7	ygien ygien her th			No	ne - Disa			N/		
and	e filec ntal H ed ot	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Name Mildred		Maid e n Surnan	ne)	
يَ	buld buld Mel	ľ	George Stuart Parker 19a. Informant's Name/Relationship (Type, Print) 191	h Mailir	ng Address (Street a			r City or Town	State Zin (Code)
Ma	12 shoulth an 27 is r trau		Mary Lee Carruth/Sister	3140	Gallahad	Drive '	Virginia	a Beach	, Vir	ginia 23456
re,	1 and of Hea item		20a. Method of Disposition 20b. Place of	of Dispo	sition (Name of natory or other place	9)	Date	20c. Location	1 - City or To	own, State
<u><u>ä</u></u>	Page ment ant: It ury or		I Bullai 2 A Olemation 3 L Removal nom State	o1 C	rematory	10/0		Dover,		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licenses Noive		Name and Addres			eral Ho enton,	-	
			23a. Part 1. Enter the disease, or complications that caused the death. Do						Ť	Approximate
إيسر	Physician/		shock, or heart failure. List only one cau it on each line. Immediate Cause (Final disease or condition	00	ARDIA	TNE	2400	TION		Interval Between Onset and D
	Medical Examiner		resulting in death) a. Due to (or as a consequen	of):	Λ	- 4.41	71100	110		ala a a
	LXammer	Į.	Sequentially list conditions, b. 111121150	IV	E CA	DIOVIT	SCULA	4 USE	ne c	chrone_
	ed isit	dical Examiner	if any, leading to immediate Dult (or as a consequence cause. Enter Underlying Cause (Disease or iinjury	OT):						
	ate be executed hysician and the burial-transit	Exa	that initiated events c Due to (or as a consequence	of):						
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Bo	es that the death igned by the atte be detached for	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ∟	Other (specify)					
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Ξ	Physic this c	은	1 Hospital: 1 Inpatient 2 ER/C 27. Manner of Death 28a. Date of injury 28b.	utpatie		4 □ Nursing Ho				y)
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Division of Vital Records,	tal or A		building, etc. (Specify)				City or Tou	vn, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check 2 Medical Examiner: On the basis of examination and/only one) 3 Certifying Nurse Practioner: To the best of my knowledge	or inves	tigation, in my opinio	on, death occurred a	t the time, date a	and place, and o	due to the ca	ause(s) and manner stated.
	To the within 2 To the comple	2	29b. Signatus and title of certifier	2.1	29c. License			29d. Date sign		
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_			30. Name and address of person who completed cause of death (Item 23a)	(Type, F	EW7DN	MD 24	629			
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 7 2011 32. Registrar's Signature	1						
	1091011		VOI VI ZUII AMANA							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:00 P M Samuel J. Ross Sr. 2011 October Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Prince George's Hospital Cheverly If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1 X M 2 🗆 F 91 249-28-0224 South Carolina Director 1920 <u>March</u> Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Prince George's 1 🏋 Yes 2 🗆 No Riverdale MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20737 5410 67th Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces' Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black 3 X Widowed 4 □ Divorced Completed Year or Dates. Army permit, Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Caretaker 4th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jefferies Florance Fletcher Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Patterson/ Daughter 9109 Taylor Street, Springdale, Maryland 20774 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) MD Veterans Cemetery 10/14/2011 Cheltenham, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Cerebral anox 1 disease or condition resulting in death) Medical Examiner dupinimanam Sequentially list conditions if any, leading to mimediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Cardio villar To the Hospital or Attending Physician: The law requires that the death certificate be executed and -trans resulting in death) Last attending physician for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ Unknown g Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Parkinson's Distage Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown demention 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has le 2 autopsy page perforn death? Hupethyrofdism 1 Yes 2 No certificate 1 Yes 2(UN Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ည 1 🗌 Yes ER/Outpatient 3 DOA 1 🗹 Inpatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify) this c 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After work? 1 Natural 5 Pending iniurv within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 Accident Investigation 3 Suicide
4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0043662 2011

State

Registrar

Hospita/ 3001 HOSPITAL DR. CHEVERLY, MD 20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

1 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death RUBERTS Physician/ Month BERTHA 2011 セメ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 218-09-4113 Hours Min. **Director** 1 🗆 M 2 🗷 F 91 3/9/1920 Maryland Usual Residence of Decedent r 28a-f show notified at 10b. County 10d. Inside City Limits 10a State 10c. City. Town or Location Director Annapolis Anne Arundel Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral USA 21401 7 Rickover Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 nan "natural", Medical Exan If Yes, Give Year or Dates 1 Yes 2 No Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 |
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event". (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) State Government Claims Analyst 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Matilda Mayr John Baptiste Haas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7 Rickover Court, Annapolis, MD 21401 19a. Informant's Name/Relationship (Type, Print) Norman J. Tucker Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Mem. Gardens 10/3/11 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Tome 21. Signature of Funeral Service License 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line set and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a conseque that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death the Unknown 9 Unknown signed by significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 1 Yes 2 No To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes Impatient 2 ER/Outpatient 3 DOA မ completely filled in by the funeral 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniurv work?
1 Yes 2 No Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certi ed cause of death (Item 23a) (Type, Print) YYTDEFENSE HWY ANNAPOLIS NA un MICHAEL

State Registrar 31. Date filed (Month, Day, Year)

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 20°11 6:47 P M Mary Alice Kinnamon Raughley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Caroline Denton Caroline Nursing Home Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🛣 F Dec 27, 1915 Maryland 95 Director 220-01-3184 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 28a-f 1 ☐ Yes 2 X No Greensboro Maryland | Caroline ö 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? iral", or items 23a Funeral USA 12770 Ridgely Road 21639 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Completed by altimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify: "natural" 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) restaurant managing owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Anne Ross Walter Harman Kinnamon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 12770 Ridgely Road; Greensboro, Maryland 21639 William A. Jones/ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Oct 8 2011 Greensboro, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery 22. Name and Address of Facility PO Box 160; Greensboro, Fleegle and Helfenbein Funeral Home, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Exami Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ lor or Attending Physician: The law requires that the death in the past 12 months? Month Year Day 2 No To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this Certificate: 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Tes 2 No Investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Registrar DHMH 17 Rev 7/2009

State

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

OCT 0 5 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2 Gettiying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gettiying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ulio Cesar Ri	vera-f	Pineda S 1- For State Registrar	tate of Mary		artment o ertificate o			Mental		Reg. No.	20	The same of the sa	3365
Physic		1. Decedent's Name (First, Mid-		inada					2. Date of De Month October		Year	3	Time of Death
Medical Exar	niner	Julio Cesar				4b. City. To	own, or L	ocation of Dea			c. County of D	eath	
		Prince Georges Hosp				Cheve				1	Prince Geo	rge's	3
Funera	al	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)		r 1 Year	If Under 24			1/DD/YYYY) 9.	reign	
Directo	r	n/a	1 M 2 F	24	Yrs	Months s.	Days	Hours M	Mpril	. 28,	, 1987	Coun	_{try)} Honduras
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E			ngton		aston								1 Yes 2 No
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f she	10 10	19a. Informant's Name/Relation							or Rural Route N			tate, 2	Zip Code)
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Baltimore, permit. Pages I ar Department of Hee Important: If ite	otner i	1 Burial 2 Crematic	on 3 Remova	I from State	crematory or o	ther place)			0-14-11				Honduras
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Physicia		23a. Part 1. Enter the disease, of	or complications that e on each line.	t caused the deat	th. Do not enter	the mode o	of dying, s	uch as cardia	c or respiratory a	arrest, sh	nock, or heart		Approximate Interval Between Onset and
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Box 68760, e death certificate but the attending physic	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	44-	s, outcome of pre e birth		etal death	3	Ectopic pre	gnancy	2	3d. Date of del Month	Da	y Year
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D. D.	드	Part II. Other significant cond			t resulting in the	underlying	cause giv	ven in Part I.	23e. Dio	tobacco	o use contribut	e to th	ne cause of death?
Division of Vital Records, P.O. rai or Attending Physician: The law requires that the safter death.									1 🗆 \	res 2	✓ No 3	Proba	bly 4 Unknown
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Div	erilea	3 Suicide 6 Co		(fy) Local Str	eet				or Town 1800 Blk Ad	i, State) ddison I	Road, Capita	I Hei	ghts, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici		(Check only 1 Certifying	Physician: To the laminer:On the bas	best of my knowle	edge, death occu	urred at the	time, dat	e and place, a	and due to the ca	ause(s) a	and manner as	stated	d. cause(s)
To th	Medical	29b. Signature and title of certi	and manne				License		_ at the time, de		I. Date signed		
	-	255. digitate data title of certific	1 .//	MS			O.C.N				ctober 2, 20	•	,
0 5		30. Name and address of person	on who compléted c	ause of death (Ite	em 23a)			-					
P		Melissa Brassell, MD		Medical Exam		V. Baltim	nore St	reet, Baltir	nore, MD 21	223			
,	State	31. Date filed (Month, Day, Yea	32:	Registrar'n Signa	atura es	-							

ORIGINAL

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			Registrar 1. Decedent's Name (First, Middle, Last)	Cen	incate of D	eatri	2. Date of Deat	eg. No.C U	3. Time of Death
	Physicia Medic		Joseph Miles Smith				Septembe		
	Examin		4a. Facility Name (if not institution, give street and number) Holy Cross Hospital		4b. City, Town, or Silver S			4c. County Montg	of Death Somery
	Funeral Director		5. Social Security Number 6. Sex $1 \times 1 $	yrs. last birthday) 3 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Feb. 3,	^Y 1938	g. Birthplace (State or Foreign Country) KY
	_ M		Usual Residence of Decedent						10d. Inside City Limits
	yland -f sho ed at	향		Oc. City, Town or Loc					1 \(\sum \) Yes 2 \(\frac{1}{12}\) No
	e Mar r 28a notifi	ire	Maryland Montgomery 10e. Street and Number	Silver S	10f. Zip Code			0a. Citizen of V	
	with th	Funeral Director	10612 Glenwild Road		20901			USA	
030	should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Completed by Fun	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	If	/as Decedent of His Yes, specify Cubar	, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian, kk, White, etc. White
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מ מ	filed wi al Hygid I other vent, t	Be (17. Father's Name (First, Middle, Last)	1		18. Mother's Nam	e (First, Middle, N	laiden Surname	a)
ylar	Ild be f Menta Iarked atic e	P	Everett Miles Smith			Margaret			
	12 shou alth and 27 is rr r traum	Ì	19a. Informant's Name/Relationship (Type, Print) Margaret R. Smith / Wife	19b. Mailin 10612	g Address (Street a	nd Number or Run l Road, S	al Route Number, Silver Sp	City or Town, S oring, I	State, Zip Code) MD 20901
Baltimore,	Page 1 and 2 should be ment of Health and Ments ant: If item 27 is marked ury or other traumatic e		4 Double A Orangellan O Double of State	20b. Place of Dispos cemetery, crem Metropoli	atory or other place		oper 44		City or Town, State
Baltıı	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	F ²²	Name and Addres	scoffins	Funera1	Home,	
			23a. Part 1. Enter the disease, or complications that caused the shock or heart failure. List only one cause on each line.						Approximate Interval Between
-	hydician/		Immediate Cause (Final disease or condition Adenocar	cinoma of	Lung				Onset and Death 1 yr
	Medical Examiner		resulting in death) Due to (or as a c	onsequence of):	. 18				
H		ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a c	onsequence of):					
	Gransit and a	cami	cause, Enter Underlying Cause (Disease or injury that initiated events C.						
	e exec cian ar ourial-ti	dical Examiner	resulting in death) Last Due to (or as a c	onsequence of):					
/60	cate b physia the b	edic	d						
89 x09	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at ti	Fetal death 3	Ectopic pregnanc Other (specify)	у	_		ate of del ivery onth Day Year
0	at the d by th	Phy	9 Unknown Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tol	pacco use cont	ribute to the cause of death?
S,	requires that the de been signed by the should be detached	d by	Pulmonary Emboli, Deep Venor				1 🗆 Y	es 2X No	3 Probably 4 Unknown
Division of Vital Records,	law requ has beer je 2 shou	Completed	Atrial Fibrillation				24a. Was a	SV	Were autopsy findings available prior to completion of cause of
Y.	: The la cate ha						perfor 1 Yes		death? 1 Yes 2 No
ца	ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 XNo Hospital: 1 Inpution	2X ER/Outpatier	Othe	er:	ome 5 🗆 Reside	noo e □ Oth	or (Spanihi)
010	g Physer this neral d	te: To	27. Manner of Death 28a. Date of njury	28b. Time of	28c. Injury work	at	28d. Describe ho		
ou	ending sath. or: Afte he fun	ficat	2 Accident Investigation	ear) Injury	M 1 □	Yes 2 No			
NISI	al or Attending Physis a after death. I Director: After this cod in by the funeral director.	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e, Place of Injury building, etc. (At home, farm, stre Specify) 	eet, factory, office		28f. Location (Si City or Town		er or Rural Route Number,
	fospital or 4 hours afte uneral Dir ed filled in	edical	29a. Certifier (Check 2 Medical Examiner: On the basis of examiner)	/ knowledge, death on the contraction and/or investing and/or investing and/or investing and/or investing and the contraction	occured at the time	, date and place, a	nd due to the cau at the time, date ar	se(s) and mann	ner as stated. ue to the cause(s) and manner stated.
	To the Hosp within 24 ho To the Fune completed f	Me	only one) 3 Certifying Nurse Practioner: To the be	st of my knowledge, o	death occurred at the	e time, date and pla	ce, and due to the	cause(s) and m	anner as stated. ed (Month, Day, Year)
	(8) 12		X 7 9/-	200		6120		Dr +	- 3 2011
			30. Name and address of person who completed cause of dear	th (Item 23a) (Type, F				001	
			1= Delean 10710 Ch	arker !	7- C	olumb.	6 170	210	244
	Star Registra		31. Date filed (Month, Day, Year) OCT 0 6 2011	Signature	w.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 October 0135 A M Frances Martha Streets Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Cecil Union Hospital Elkton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** Months 1 M 2 X F Days Hours Min JAN 29 Year 936 De laware 215-32-6779 75 Yrs. Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 🗌 Yes 2 🔀 No Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hygiene. other than "natural", or items 23a or ent, the Medical Examiner must be r Funeral 60 St. Michaels Court 21921 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. ģ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Bookkeeper Accounting ed other event, th Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any liniry or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Lillian D. Cross William E. Clarke, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 St. Michaels Court, Elkton, MD Michael A. Streets/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 17 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co., Inc. West Chester, PA 2011 22. Name and Address of Facility Hicks Home for Funerals, P.A. ure of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) 4 Pregnant : 9 Unknown Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♠ No 24a. Was an autopsy performed? 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Investigation 2 Accident 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🕻 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only or 29b. Signature a 29d. Date signed (Month, Day, Year) · Su

State Registrar 104 W. Main Street, Elkton, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

John R. Mulvey, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 4 Month October 3:25AM Physician/ Helena hannon laimi Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death **Examiner** Montgomen Olney general Montgomeny Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 015-18-9707 **Director** 1 □ M 2 🖾 F 89 Sept. 9, 1922 MA Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location at 10a. State Director Examiner must be notified 1 ☐ Yes 2X No MD Montgomery Silver Spring 10g, Citizen of What Country? 10f. Zip Code 10e Street and Number ō 23a Funeral 3833 Wendy Lane 20906 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black White etc. o 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🖾 No Specify. If Yes, Give other traumatic event, the Medical Exar 3₺ Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) Callege (1-4 or 5+) Data Processor Computer Technology Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) မ Emil A. Niemi Anna H. Hiltunen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau William E. Shannon/Son 3833 Wendy Lane, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date Dec. 9, 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 2011 Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, Signature Funeral Servin Licensee I Dates Duhard MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ommunity acquired disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** obstr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine with multion attending physician and for use as the burial transfer Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2,2 9 ☐ Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by diffale Division of Vital Records, colitis, 2 No 3 Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Director: After this certificate Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral of 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: work? 1 Yes 2 No 1 Natural injury 5 \square Pending 2 Accident
3 Suicide
4 Homicide Investigation etely filled in by the Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ch October 4 2011 CHINTU SHARMAND D 00 69086

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

16101

Prince Philip Dr. Olivery

CHINTU SHARM MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - general

0 6 2011

hospital

Registrar's Signature

		Pleas	e type or Prin					-	_	DIG.	
	_	For	State of Ma	iryland							
		State Registrar			Cer	tificate of L	Death		g. No2		33660
Physiciar Medica	1/	1. Decedent's Name (First, Middle, L	_{-ast)} amantha Eli:	zabez	th Sar	ang		2. Date of Death Month Octobe	T 02,20	Year 11	3. Time of Death 1:00 am
\ Examine		4a. Facility Name (if not institution, g	ive street and number)				Location of Death	Lara Technology	4c. County of	of Death	
		Holy Cross				1	er Spring				zomery
Funeral Director		579-66-3124	. Sex 1 □ M 2 🔏 F 7. Age	(In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 02/24/	1939	9. Birthpi Counti	lace (State or Foreign ry) Germany
and show d at	- h	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo					10	Od. Inside City Limits
ne Maryl or 28a-f notifie	Funeral Director	Maryland Mont	gomery			Si 10f. Zip Code	lver Spri		og. Citizen of W	hat Count	1 Yes 2 X No
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deat riten ineri		11. Marital Status1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Ex Armed Forces?		. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)		- America , White, e	
ırs after ural", o I Exam	ted by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 汉 ↑ If Yes, Give Year or Dates.	No		1 ☐ Yes 2 💆 No	Specify:		Specify:	Cau	icasian
2 hou "natu	Bet	15. Decedent' (Specify only highest	s Education grade completed)		16a. Dece	dent's Usual Occup kind of work done	oation during most of work	ing	16b. Kind of Bu	siness Ind	ustry
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d be f Aenta arked tic ev	၉	E	wald Eitelb	erg_				Bert	a Heela	.nd	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship Sabina Silkword		Л.	19b. Maili	ng Address (Street Countrus	and Number or Run ide Dr.,	al Route Number, (Silver S	City or Town, St	ate, Zip C	ode) 0905
and Heal		20a. Method of Disposition		20b. Pl	ace of Dispo	osition (Name of			20c. Location -		
bage lent of nt: If i		1 ☐ Burial 2 🔀 Cremation 3 4 ☐ Donation 5 ☐ Other√Sp		Ft.	emetery, crei Li.n.c.o	matory or other place. Ln. Crema	tory 10/1	0/2011 1	3rentwo	od, N	laryland
mit. F partm porta y inju		21. Signature of Euneral Service Lic		p	2:	2. Name and Addre	ess of Facility Hin	es-Rinal	di Fune	ral	Home, Inc.
B E E		SIMA	MOB	94						prin	g, MD 2090
		23a. Part 1 Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final	y one cause on each line					or respiratory arres	st,		Approximate Interval Between Onset and Death
Physician/ Medical		disease or condition resulting in death)	a. Cong	esti	ve Hed	urt Failu	re				weeks
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7 A	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequ	ence of):						
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physic the t	edic	**	d .	-							
certificanding	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnal	ncy	☐ Ectopic pregnan	CV		23d. Dat	e of delive	*
e death the atte	Physician/Media	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4 Pregnant at			Other (specify)			Mor	nth	Day Year
hat the sd by detac		Part II. Other significant condition	s contributing to death b	ut not res	ulting in the	underlying cause g	iven in Part I.	23e. Did tob	acco use contr	ibute to th	ne cause of death?
uires t n sign lid be	ed by	Obstructive S	leep Apnea,	Нуре	rtens.	ion		1 □ Y€	es 2 🗓 No	3 🗌 Prob	bably 4 🗆 Unknown
as bee 2 shou	Completed	Coronary Arte	ry Disease,	Нуро	album	inemia,		24a. Was ar	y F	rior to co	psy findings available mpletion of cause of
The la	Con	Chronic Kidne	y Disease Sa	tage:	2			perform		leath?	2 🗆 No
cian: ertific ector,	Be (25. Was case referred to medical examiner?	Legaite!				Place of Death (Chec	k only one)	434		
hysic this c	To Be	1 Yes 2 X No				ent 3 DOA Oth	4 ☐ Nursing H	ome 5 Reside)
ding F ith. : After i	cate	27. Manner of Death 1 💆 Natural 5 🗌 Pending 2 🔲 Accident Investiga			28b. Time of injury	wor		28d. Describe ho	w injury occurre	ea	
or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determir	ot be 28e Place of Inju			reet, factory, office		28f. Location (St. City or Town		er or Rural	Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physempleted filled in by the funeral director, page 2 should be detached for use as the	Medical (29a. Certifier 1 X Certifying	Physician: To the best of	my knowl	edge, death	occured at the time	e, date and place, a	nd due to the caus	se(s) and manne	er as state	ed.
the Hc nin 24 the Fu npleter	Med	only one) 3 Certifying I	aminer: On the basis of ex Nurse Practioner: To the	kamination best of my	and/or inve knowledge,	death occurred at t	he time, date and pla	ice, and due to the	cause(s) and ma	inner as st	tated.
E time ags		29b. Signature and title of certifier	randar	J		29c. Licens	D 5 3 3 6 7	2	9d. Date signed		Day, Year)
•		30 Name and address of person w	ho completed cause of d	eath (Item	23a) (Type,	Print)					
		Shyamsundar Raj	an, M.D., 9	801	Beorgi	a Avenue,	, #117, S	ilver Sp.	ring, M	aryli	and 20902
Stat	e	31. Date filed (Month, Day, Year)	32 Registra	ar's Signat		and .					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 3366 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ORIS DMITH)EAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center Allegany Kegional Medical umberland If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 1 🗆 M 2 🗷 F (Month, Day, Year) 5-1-1930 Min. 17-28-0120 81 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Somerset Meyersdale 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? umberland Highway Funeral items 23a 1555 6504 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian "natural", or iter edical Examiner Armed Forces Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: VVInit Completed 3 K Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Ciothing Manufacture 12 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) age 1 and 2 should be fill not of Health and Mental to If item 27 is marked of Iroutman Mayne Blanche 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PA 15552 Meyersdale Cumberland Troutman HWY aro Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 🗷 Burial 2 🗌 Cremation 3 🗹 Removal from State injury or Department Important: If any injury or 30-Cemetery COKS Wellersburg 4 Donation 5 Other (Specify) 169 Clarence 21. Signature of Funeral Service Licensee 22. Name and Address of Facility F.H. INC HYNDMAN PA 15545 H. Zeigler 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Use to (or as a nonsequence of) burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death signed by the a Yes 2 No 9 Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? death? After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accider
3 Suicide Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221- E. National Hwy La Vule MO 21502 Khanna Mo

State Registrar 32. Registrary Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Scholze, Jr. Ellis Robert Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Western MD Regional Medical Center Cumberland Allegany 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Days Hours 06/17/1934 1 👿 M 2 🗆 F 267-48-8603 77 Florida Director Usual Residence of Decedent 28a-f show 10a, State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Cumberland Allegany 1 Yes 2 X No 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? traumatic event, the Medical Examiner must be Funeral itеms 23a USA 10108 Golf Creek Drive, NE 21502 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ö þ 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: "natural", 3 Widowed 4 Divorced Specify. Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Senior Sales Executive Financial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ပ Robert Ellis Scholze, Sr. Dorothy Palmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, f Health gitem 27 i Sheila Day-Scholze / Wife 10108 Golf Creek Drive, NE, Cumberland, MD 21502 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Cumberland Crematory 10/04/2011 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) parture of Funeral Service License 22. Name and Address of Facility Adams Family Funeral Home, I.A. any 404 Decatur Street, Cumberland, MD 23a. Pand Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Preumonio Physician/ disease or condition resulting in death) 6 days Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death 2 No ate has been signed by the a page 2 should be detached g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has k autopsy 1 Yes 2 No 1 Yes 2 No To the Funeral Director: After this certifical completed filled in by the funeral director, it Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

eath (Item 23a) (Type, Print)

CRNP

4 201

R194 124

12500 Willow brook Rd

21502

Cumberland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0108AN Dorothy Simmons Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany WMHS-RMC Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) Country) MD 1 M 2 XF Hours May 11 1 1936 214-32-2936 **Director** 75 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location **Funeral Director** MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 517 Shriver Avenue 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕍 No If Yes, Give Year or Dates Specify Specify: 3 🖾 Widowed 4 🗌 Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working College (1-4 or 5+) life. DO NOT use retired) Elementary/Seconday (0-12) Registered Nurse Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Dorothy Smith John Stull 19a. Informant's Name/Relationship (Type, Print)
Ann Marie Smith Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801 Hicks Avenue Cumberland MD 21502 daughter Department of Health Important; If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Rocky Gap Veterans Cemetery 10/15/20 Flintstone MD 4 Dentation 5 Other (Specify) 22. Name ar Scarpenif Full Eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death ed by the a 1 ☐ Yes 2 L 9 ☐ Unknown After this certificate has been signed by t funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 Natural 5 Pending Accident Investigation filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 8N 30. Name and add State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** \mathbf{A}^{M} October 6, 2011 Mary Elizabeth Sickles 6:15 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Sacred Heart Home Prince George's Hyattsville If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days 1 □ M 2 🛛 F May 8, 1920 Washington, DC 578-18-7838 91 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 1 Tx Yes 2 □ No Funeral Director Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be 20782 5805 Queens Chapel Road USA 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Completed by 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Legal Secretary Real Estate traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be s 1 and 2 should be fil Health and Mental H tem 27 is marked otl William David Kranking Leona G. Laughrige 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 to Department of Health ar Important: If item 27 is any injury or other trau Clare G. Wendal / Daughter 3118 St. Johns, Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 10/8/2011 Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Cons Gasch's Funeral Home, P.A. Hyattsville, MD 20781 ase 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FUV **Physician** ongestive /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Vear Day 4□Pregnant at time of death 5 Other (specify) ed by the a Division or Vital Records, P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed this certificate Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Pla of Death Check onl one Be Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Mariner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 V Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd, Ellicott City, MD Ligen 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Vanschark, Richard

			Please 1 - State Registrar		nt in Black II aryland / Depa Cea		lealth and	Mental Hy	giene 201	ble. 1 33665
	Physicia Medi		1. Decedent's Name (First, Middle, La Richard Van	Schaik		inouto or a		2. Date of Dea		3. Time of Death
-	Exami	ner	4a. Facility Name (if not institution, given the second se	We street and number)	al	4b. City, Town, o	r Location of Death	n	4c. County of	
	Funeral Director		218-34-8739	Sex 7. Ag	e (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl April	21,1938	9. Birthplace (State or Foreign Country) New Jersey
	aryland a-f show ified at	ector	Usual Residence of Decedent 10a. State 10b. County Manual and Canala	:	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🌠 No
	with the M 23a or 28 ist be noti	Funeral Director	Maryland Carol: 10e. Street and Number 8571 Briar Patch		Dento	10f. Zip Code 2162	Ω		10g. Citizen of W	hat Country?
9036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at	हि	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	12. Was Decedent E	No		ispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race	- American Indian, , White, etc.
1215-(thin 72 hounne. Than "natu Than "natu	Completed	15. Decedent's (Specify only highest g Elementary/Seconday (0-12) 12 H.S. Grad.	Education rade completed) College (1-4 or 5	+) (Give I	O NOT use retired)	during most of won	king	16b. Kind of Bus	siness Industry
Baltimore, Maryland 21215-0036	should be filed within and Mental Hygiene. is marked other that raumatic event, the M	10	17. Father's Name (First, Middle, Last) Cornelius Van Sch		Bus	iness Own			Automot: Maiden Sumame)	ive Repair
e, Mary	and 2 should Health and M tem 27 is ma ther trauma		19a. Informant's Name/Relationship (Jeffrey Van Schaf		8659	Van Scha	and Number or Rui ik Lane		r, City or Town, Sta	
ltimore	Page nent c ant: If any or		20a. Method of Disposition 1 A Burial 2 Cremation 3 [4 Donation 5 Other (Spec	ify)	Denton Ce	metery metery	10/0	Date 08/2011	Denton,	Maryland
Ba	permit. Departr Imports any inji		21. Signature of Funeral Service Licer	/hoore	_ 1		Second St	reet :		me, P.A. Maryland 21629
0	Physician/ Medical Examiner he privial-transit	dical Examiner	23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c.	P		RRES		UPPKE	Approximate Interval Between Onset and Death
. Box 6876	that the death certificate bed by the attending physidetached for use as the t	· ·	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of Live Birth 2 Pregnant at 9 Unknown	2 🗌 Fetal death 3 🔲	Ectopic pregnanc Other (specify)	у		23d. Date Mont	of delivery h Day Year
ords, P.O.	w requires that the solution of the solution o	Completed by Pl	Part II. Other significant conditions of						∕es 2 □ No 3	ute to the cause of death? Probably 4 Unknown ure autopsy findings available
I Rec	sician: The law is certificate has the law inector, page 2 s		25. Was case referred to medical					autop perfor 1 🗆 Yes	sy pri med? de 2 No 1	ere autopsy findings available or to completion of cause of ath?
Division of Vital Records,	ng Phy fter this ineral d	Certificate: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of injur (Month, Day,	Year) injury	3 DOA Othe	at Nursing Ho	ome 5 Residence 28d. Describe ho		
Ω	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	(Check 2 - Medical Exam	iner: On the basis of ex	ny knowledge, death or amination and/or investi est of my knowledge, de	gation, in my opinio	n, death occurred a time, date and place	t the time, date ar ce, and due to the	nd place, and due to cause(s) and mann	o the cause(s) and manner stated ner as stated.
D	F > F 0		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type, Pr	DI	1664		29d. Date signed (1)	2011
	Stat	e ³	C, E, JENSON / B1. Date filed (Month, Day, Year) OCT 0 7 2011	10, 708 - 32. Registrar	7690 DE	NON	MD2	1629		
	Registra		441 A 1 MII	and and		-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 33666 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Alice Louise Toler Month Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Western MD Regional Medical Center Allegany Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/28/1930 g. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min Hours 1 🗆 M 2 🖫 F Director 215-26-6560 81 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director Allegany Corriganville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 10507 Lowery Lane 21524 USA Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mus Page 1 and 2 should be filed within 72 hours after death . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Duckworth James Ruth Dicken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Braddock Street, LaVale, MD Josephine Lavin / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Hermon Cemetery 10/08/2011 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) Adams Family Funeral Home, P.A. Signature of Funeral Service Licenses 22. Name and Address of Facility 404 Decatur Street, Cumberland, MD 21502 00 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Phonacians/ disease or condition resulting in death) EUMONIA Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No jo Day Month Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 **3** 9 ☐ Unknown be detached the signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Director: After this certificate has autopsy perform Yes 2 No 2 🗌 No 1 🗌 Yes Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) P 1 Tes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 To the I only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 195737 10 -6-2011 zamoal 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Awuah-Asamoah,

OCT 0 6 2011

31. Date filed (Month, Day, Year)

32. Registrar's Signature

CRNP, 12501 Willowbrook Rd, Cumberland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 Physician/ 2011 10:25P ^M Isadora С. Taitano Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Temple Hills Prince George 6635 Allentown Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X 4/4/192 216-46-3918 90 Director Guam Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 ☐ Yes 2 🏋 No Maryland Prince George Temple Hills 10e. Street and Number 5 10f, Zip Code 10g. Citizen of What Country? Funeral items 23a 6635 Allentown Road 20748 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ื No Specify: If Yes, Give Year or Dates Specify.Guamanian 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ပ Jose Μ. Camacho Catalina Eclavea 5 1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Browne/Granddaughter 6635 Allentown Road Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Arlington Nat'l. Cem | 11/10/2011 4 Donation 5 Other (Specify) Arlington, Virgina 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill. MD 20745 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ause on, ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician) disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE es, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Month Pregnant at time of death Day signed by the at d be detached for the Part II. Other significant populitions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s After this certificate has performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 24 hours after death.

Funeral Director: At 2 No Accident Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33668 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 Day 05 2011 Petrona Zelaya Physician/ Umana 16:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Olney Montgamery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** 6. Sex Age (In yrs. last birthday) 1 🗆 M 2 🗓 F Hours "Salvador 0270871925 86 Director Usual Residence of Decedent 28a-f show pernit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other than "nature". 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 XYes 2 No Maryland Rockville Montgamery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5416 Marlin St. 20853 El Salvador 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 XYes 2 No Specify: Specify: 3 🕅 Widowed 4 🗆 Divorced Salvadorian White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jose Zelaya Angela Umana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jose Zelaya (Son) 5416 Marlin St. Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 10/12/2011 Silver Spring, MD Gate of Heaven Cem. 4 Donation 5 Other (Specify) Rendon/Hale Funeral Home 22. Name and Address of Facility 21. Signature Funeral Service Licensee 9013 Annapolis Rd. Lanham, MD 20706 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed neumonia Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death signed by the a g Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown peen Were autopsy findings available prior to completion of cause of .24 hours after death.

e Funeral Director: After this certificate has weted filled in by the funeral director, page 2 ! autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မှု 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Datę signed (Month, Day, Year) D0068026 10/05 2011 MD Name and address of person who completed cause of death (Item 23a) (Type, Print) ause of death (Item 23a) (Type, Print) Prince Philip Dr. Olney pandi dmaja 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar 33669 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 October 8:40 PM Medical Margaret Anne von Brand 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 6 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Hours Min. Washington, D.C 1950 Yrs **Director** 216-60-3188 61 Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Poolesville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 17108 Campbell Farm Road 20837 United States items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 1 Married "natural", or 1 Yes 2 If Yes, Give Year or Dates. 2 🔀 No Baltimore, Maryland 212/5-0036 1 Yes 2 K No Specify. White Specify: Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working than Elementary/Seconday (0-12) College (1-4 or 5+) Banking Vice President of Operations other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of ပ္ Edward M. Carr Catherine Agnes Redmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Andrew Theodor von Brand/Spouse 17108 Campbell Farm Road, Poolesville, MD 20837 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cem. 10/07/2011 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee DeVol Funeral Home Mª Millian MO1202 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatiz One year disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner hrambaem Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying pue to for as a consequence of burial-transif Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown the be detached g Unk*n*ow*n* signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? hours after death. Ineral Director: After this certificate 2. X No Yes 2 N or Attending Physician: 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be the 1 Accident Suicide within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: On the basis or examination around investigation, in my spanier, source data the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12 MDO6033 S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Phi Bannen MD 18111 ney MD 20852 6 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4a. Facilite Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death ounty of Death love 8. Date of Birth (Month, Day Yo Aug. 15, Security Number If Under 24 Hrs 9. Birthp **Funeral** 1 D M 2 🔀 Country) WV Days 229-34-7747 Hours Director 85 Yrs. Usual Residence of Decedent show an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits **Funeral Director** Rockville MD Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20853 14001 London Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 🙀 No If Yes, Give Year or Dates 1 ☐ Yes 2 1 No Specify: Specify.White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Medical Medical Technologist Ith and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Dorothy Guy Frank Echols 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 5821 Robin Street, Mt. Jackson, VA 22842 Evelyn W. Showman/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Glasgow Cemetery 1 X Burial 2 Cremation 3 X Removal from State Oct. 4 ☐ Donation 5 ☐ Other (Specify) Glasgow, VA 2011 permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) months Medical Due to or as a consequence of Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter on penying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar for use as the buris Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death ed by the a detached f 1 ☐ Yes 2 ≠ 9 ☐ Unknown g Unknown Division of Vital Records, P.O. signed by Part II. Other significant ponditions contributing to death but pot resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à pe 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes page 2 should within 24 hours after death.

To the Funeral Director. After this certificate has been completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature

State Registrar 10110 Molecular

e and address of person who completed cause of death (Item 23a) (Type,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Wolford Physician/ Harvey John Medical 4c. County of Death Allegany 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death
Cumberland Examiner Western MD Regional Medical Center If Under 24 Hrs Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** Days 1 🗶 M 2 🗆 F 0876971945 Mary Land 215-42-2694 66 **Director** Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland Director 1 Yes 2 No Cumberland MD Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA Funeral 13406 Pershing Street, SW Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", Completed 3 Divorced 4 Divorced 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Hospital uth and Mental Hvorage is mark Be 18. Mother's Name (First, Middle, Maiden Surname) Helen Grace 17. Father's Name (First, Middle, Last) Ernest Hamilton Wolford Morton ၉ t. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13406 Pershing Street, SW, Cumberland, MD Debra A. Wolford / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Page 1:
Department of I
Important: If it
any injury or of 1 X Burial 2 Cremation 3 Removal from State MD Vet Cem @ Rocky Gap 10/07/2011 Flintstone, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, ignative of Funeral Service Licensee daro 404 Decatur Street, Cumberland, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 20 10 adys disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Pregnant at time of death 2 No been signed by the should be detached g Unknown a Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a. Was an autopsy performed , page 2 has within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Registrar DHMH 17 Rev 7/2009

5+

(Check

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Rustolu

06

30. Name and address of person who completed call Christopher Vagnoni,

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

e of death (Item 23a) (Type, Print) M.D., 12500 Willowbrook Rd, Cumberland, MD

29c. License number D005998 29d. Date signed (Month, Day, Year)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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per FD	•	1 - State Registrar		,	Cer	tificate of	Death		,	Reg. N	6. U I		3672
Physicia Medic		1. Decedent's Name <i>(First, Middle</i> Larry	e, <i>Last)</i> Rona	ld		Wolfe			2. Date of De			ear .	Time of Death
Examin		4a. Facility Name (if not institution Western MD Reg	, give street and nun sional Med	nber) ical Ce	nter	4b. City, Town,		of Death erland	ì	40	c. County of		у
Funeral Director		5. Social Security Number 214–36–6767	6. Sex 1 ★ M 2 □ F	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Day			8. Date of Bir (Month, Da 04/10	ay, Year)		Birthplace (Country)	State or Foreign
ind show at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loc	cation						10d. In	side City Limits
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with t s 23a ust be	Funeral	817 Trost Av	enue				2150	02		10910		USA	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 💢 Mar 3 □ Widowed 4 □ Divorced	ried Armed Fo	2 🗌 No re	l1	Vas Decedent of FYes, specify Cu	ban, Mexica	an, Puerto R	ify Yes or No- ican, etc.)			American inc White, etc.	ian,
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Baltimore, Maryland 21215-0036 Dearnit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam once.	To Be	17. Father's Name (First, Middle, I Ora	.ast) Monro	e V	Wolfe			her's Name len	(First, Middle V	, Maiden irgi		Rain	ies
b, Mar tnd 2 shou lealth and om 27 is n her traum		19a. Informant's Name/Relations Paula L. Wolfe	, , ,		817	g Address (Stree Trost Av	et and Numb enue,	ber or Rural Cumb	Route Numbe erland	er, City o MI	r Town, Stat) 2 1 5		
nore		20a. Method of Disposition 1 Disposition 2 Cremation		State C	emetery, cren	sition (Name of natory or other pi	ace)		ate	1		ty or Town, S	
altin mit. Pa bartme oortan i injury.		4 Donation 5 Other (S		Frie	rrown 22	Cemeter Name and Add	ress of Facil	10710	77611 ms am	I Ra	wline uner	a l lon	ne. F.A.
any per Berry Barry Barr		> Volue & Ci	dans			04 Decat							
Physician/ Medical		23a. Part 1. Soter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on ea	caused the death	Canel	or the mode of dy	ring, such as	s cardiac or	respiratory a	rrest,		Inter	roximate val Between et and Death
Examiner	ner	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a consequ	uence of):								
6 5.2	al Examiner	cause. Enter Underlying Gause (bisease or irright) that initiated events resulting in death) Last	c	or as a consequ	ence of):								
760 icate b	ledic		d										
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after cleath. To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	come of pregna Birth 2 Feta nant at time of d	death 3	Ectopic pregna Other (specify)	ncy				23d. Date of Month		Year
P.O that the	절	Part II. Other significant condition	1	eath but not resi	ulting in the u	nderlying cause	given in Parl	t I.	23e. Did t	obacco	use contribu	ite to the cau	se of death?
ds, quires en sig	ted	Preumor	1,2.						1 🗆	Yes 2	□ No 3	Probably	4 Unknown
Recor The law re ate has be	Completed by								24a. Was auto perfo	psy ormed?	prid		dings available on of cause of No
ician: ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:					ath (Check o	only one)				
Phys Phys r this c	일	1 Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2 of injury	ER/Outpatien 28b. Time of	t 3 DOA 28c. Inji			ie 5 🗌 Resi			Specify)	
On C ending eath. or: Afte	ficat	1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident Investi	gation	th, Day, Year)	injury	wo	rk? ☐ Yes 2 ☐	- 1	od. Describe i	low injui	y occurred		
Divisi tal or Atte rs after de al Directo	al Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 28e. Place	of Injury - At hong, etc. (Specify)		et, factory, office		28	Bf. Location (City or Tov			or Rural Route	e Number,
the Hospi nin 24 hou the Funer	Medical	(Check 2 \(\sumeq\) Medical E	Physician: To the be xaminer: On the bas Nurse Practioner: T	is of examination	and/or investi	igation, in my opii	nion, death c	occurred at the	ne time, date a	and place	e, and due to	the cause(s)	and manner stated.
3+ 1000		29b. Signature and title of contiffer			,		066	439			ite signed (A	Aonth, Day, Ye	ear)
nols		30. Name and address of person values Blanche Mavr	omatis, M	.D., 1	2502 W	illowbro	ook Ro	i, Ste	300,	Cum	berlar	nd, MD	21502
Stat Registra	e r	31. Date filed (North Day, Year) 0CT V 4 20	32. Re	egistrar's Signati	bark	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Washburn Physician/ Dickinson Month Eric 2011 Year 2:00 AMM October Medical 4c. County of Death Allegany 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Cumberland Examiner 14410 Smouses' Mill Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) 05/24/1940 1 X M 2 □ F 228-54-2693 71 Indiana Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location irector 10d. Inside City Limits notified MD Cumberland 1 ☐ Yes 2X No Allegany Ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 14410 Smouses' Mill Road USA 21502 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Veterans Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Brent Israel Washburn Margaret Dickinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14410 Smouses' Mill Road, Cumberland, MD 21502 Carolyn A. Washburn / Wife permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗌 Burial 2 💢 Cremation 3 🗀 Removal from State Cumberland Crematory 10/03/2011 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD Adams Family Funeral Home, P.A. 22. Name and Address of Facility 18 404 Decatur Street, Cumberland, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Physician/Medical Examiner Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No been signed by the atte should be detached for Month Day Year Pregnant at time of death 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Nes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy death? performed this certificate 2 No Yes 2 N 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 5 Pending 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

Registrar DHMH 17 Rev 7/2009

nas

State

31. Date filed

Industria

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

truci

11-07642

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Usual Residence of Decedent 10a. State 10b. County Maryland Freder 10e. Street and Number 6 Monocacy 11. Marital Status 1 Never Married 2 Marrie	11s ve street and number) ital Sex 7. Age (In yrs. las M 2	st birthday) 7 Yrs. Own or Location Walk	b. City, Town, or Lo Frederick If Under 1 Year Months Days on cersville 10f. Zip Code		8. Date of Birth() Jan. 16	ay Year 2011 4c. County of Deat Frederick MM/DD/YYYY) 9. Bi	
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3 Widowed 4 V Divorce	d Armed Forces? 1 Yes 2 No d If Yes, Give Year		Decedent of Hispa		ecify Yes or No-		rican Indian, Black,
3 Widowed 4 V Divorce	d If Yes, Give Year		s, specify Cuban, N			White, etc.	, 2,
15. Decedent's Education (Specify of Elementary/Secondary (0-12)		1	Yes 2 X No	specify:		Specify:	White
Elementary/Secondary (0-12)			s Usual Occupation st of working life. D			b. Kind of Business	Industry
=	College (1-4 or 5+)	during mo	st of working life. D	O NOT use real	54)		
	12	V	et Techn	ician	(First, Middle, Mai	Veterina	ry
0.			10.			·	
	OSS Type, Print)	19b. Mailing	Address (Street a				a, Zip Code)
	ompanion	6 Mon	ocacy Co	urt. Wal	karevill	a MD 217	93
20a. Method of Disposition	20b. Pla	ace of Disposit	ion (Name of ceme	tery,	Date 2	0c. Location - City or	Town, State
	L Kellioval Irolli State	•		10/1	5 /2011	E 1	. M1 1
	nsee/	22. Na	ame and Address of	f Facility			
(orthal)	Stauble	- 3	1621 Opos	ssumtown			
23a. Part I. Enter the disease, or com failure. List only one gause on e	plications that daysed the death. It	onot enter the	e mode of dying, su ardiovas	ich as cardiac or cular Di	respiratory arrest,	shock, or heart	Between Onset and
Immediate Cause (Final disease a	Tramadol Into	xicatio	n				Death
or condition resulting in death)	Due to (or as a consequence of):						
Sequentially list conditions,	Due to (or as a consequence of):						
cause. Enter Underlying Cause (Disease or injury that initiated	,						
events resulting in death) Last	_ ` ′						
X UNPENDED	· · · · · · · · · · · · · · · · · · ·	,28a-f	per me g	921 11-2	2-11 vt		
IF FEMALE:						23d. Date of deliver	<u></u>
23b. Was decedent pregnant in the past 12 months?	1 Live birth	_ =	al death 3	Ectopic pregnar	ncy	Month	Day Year
No 9 ✓ Unknow		tn 5 Oth	er (Specify)				
Part II. Other significant conditions		sulting in the un	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
6					1 Yes	2 No 3 Pro	bably 4 🗹 Unknown
					24a. Was an		utopsy findings available completion of cause of
					performe	d? death?	
			26.Place of	Death (Check of		1 1	es 2 No
	Hospital: 1 Inpatient 2 🗸 E	R/Outpatient	3 DOA Ot	her Nursing	Home 5 Re	sidence 6 Othe	r:
27 Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Inj	jury 28c. Injury a	at Work?	28d. Describe how	injury occurred	
Natural 5 Pending	fd 1-12-11	fd 11:4	5 am 1 Yes	2 X No	unknown		
3 Suicide 6 X Could no	t be 28e. Place of Injury - At hon	ne, farm, street	, factory, office buil	ÿ.	or Town State	e)	
4 Homicide determine	(Specify) found	in hous	se		6 Monoca	cy Ct. Wa	lkersville,
2 Medical Examine	and manner stated.						
Zap Signature and title of certifier	0-00						
Tate Un	- TOLL	22=1	J.O.IVI.			70.0001 10, 201	·
			900 W. Baltimo	re Street. B.	altimore. MD 2	21223	
Physician/Medical Examiner 10 Be	Jay Stephen R 19a. Informant's Name/Relationship (Pat Everly / C 20a. Method of Disposition 1	Jay Stephen Ross 19a. Informant's Name/Relationship (Type, Print) Pat Everly / Companion 20a. Method of Disposition 1	Jay Stephen Ross 19a. Informant's Name/Relationship (Type, Print) Pat Everly / Companion 20a. Method of Disposition 1	Jay Stephen Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street at Pat Everly / Companion 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donatign 5 Other Specify 21. Signature of Funeral Service Ligenage 22a. Place of Disposition (Name of Ceme crematory or Other Place) Stauffer Crematory 22. Name and Address of Tailure. List only one clause on each line. At/herosclerotic Cardiovas: 16.21 Opo. 1	Jay Stephen Ross Transport Transpor	Jay Stephen Ross Tinas Milling Address (Street and Number or Rural Route Number or Rural Route Number Pat Everly / Companion 198. Mailing Address (Street and Number or Rural Route Number 198. Mailing Address (Street and Number or Rural Route Number 198. Mailing Address (Street and Number or Rural Route Number 198. Mailing Address (Street and Number or Rural Route Number 198. Mailing Address (Street and Number or Rural Route Number 198. Mailing Address (Street and Number or Rural Route Number 198. Mailing Address (Street and Number or Rural Route Number 198. Mailing Address (Street and Number or Rural Route Number 198. Mailing Address (Street and Number or Rural Route Number 198. Mailing Address (Street and Number or Rural Route Number 198. Mailing Address (Street and Number or Rural Route Number 198. Mailing Address (Street and Number or Rural Route Number 198. Mailing Address (Street and Number or Rural Route Number 198. Mailing Address (Street and Number or Rural Route Number 198. Mailing Address (Street and Number or Rural Route Number 198. Mailing Address (Street and Number or Rural Route Number 198. Mailing Address (Street and Number or Rural Route Number or Rural Route Number 198. Mailing Address (Street and Number or Rural Route Number or Rural Route Number 198. Mailing Address (Street and Number or Rural Route Number or Rural Route Number 198. Mailing Address (Street and Number or Rural Route Number or Rural Route Number 198. Mailing Address (Street and Number of entery 198. Mailing Address (Street and Number of entery 198. Mailing Address (Street and Number of entery 198. Mailing Address 198. Mailing Address	Jay Stephen Ross Tinas Miniformaris Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Radous Number, City or Town, State Pat Ever Iv Companion 19b. Mailing Address (Street and Number of Radous Number, City or Town, State Pat Ever Iv Companion 19b. Mailing Address (Street and Number of Radous Number, City or Town, State Pat Ever Iv Companion 19b. Mailing Address (Street and Number of Radous Number, City or Town, State Pat Pat Iv Companion 19b. Mailing Address (Street and Number of Radous Number Number of Radous Number of Radous Number of Radous Numb

11-07470 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Troy Wilkins State of Maryland / Department of Health and Mental Hygiene 33675 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month **Medical Examiner** 1529 hrs WILLIAM TROY WILKINS, JR. October 5, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 108 Spruce Drive Queen Anne Queen Anne's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Country) Months Days Hours Director 217-39-2412 1 X M 2 F JULY 17,1993 18 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Inther than "natural", nr items 23a or 28a-f show the Medical Examiner must be notified at once. QUEEN ANNE MD QUEEN ANNE'S Pages I and 2 should be filed within 72 hours after death with the Maryland nen of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 SPRUCE DRIVE 21657 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes If Yes, Give Yaar 1 Yes 2 X No specify: 3 Widowed WHITE 4 Divorced Specify: þ or Dates 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) STUDENT 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) WILLIAM TROY WILKINS CHRISTINA STEVENS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 SPRUCE DRIVE, QUEEN ANNE, MD 21657 WILLIAM TROY WILKINS/FATHER Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State OCT. 11, STEVENSVILLE CEMETERY Department o Important: injury nr nth STEVENSVILLE, MD 4 Donation 5 Other Specify 2011 permit. 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME,
408 S. LIBERTY ST., CENTREVILLE, MD 21617

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

Approxim Approximate Interva **Physician** failure. List only one cause on each line Between Onset and Medical Death a. Contact Shotgun Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and led for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown this certificate has been signed by the att al director, page 2 should be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 🗸 Other; Scene 1 🗸 Yes 2 No 28a. Date of Injury FOUND: Day, Year 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject shot self FOUND 1 Natural 1 Yes 2 ✔ No 5 Pending To the Funeral Director: the Oct 5, 2011 1517 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 24 hours after 3 V Suicide 6 Could not be or Town, State) 108 Spruce Drive, Queen Anne, MD determined (Specify) Single Family Home 29a Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Bop

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Ling Li, MD

31. Date filed (Month Day, Year)

O.C.M.E.

October 6, 2011

33676 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 4Day 201 Tear JOAN VIOLA WEBER 23:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🗆 M 2 💢 F Days Months 79 Hours 1070571931 PENNSYLVANIA **Director** 170-24-1394 Usual Residence of Decedent at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f 1 Tyes 2 X No CHESTER MD QUEEN ANNE'S 10e. Street and Numbe 10f, Zip Code ō 10g. Citizen of What Country? Funeral 23a UNITED STATES 1717 BAYSIDE DRIVE 21619 items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. I Hygiene. other than "natural", or i Completed by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 Divorced Year or Dates Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OFFICE ADMINISTRATION 12 SECRETARY Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ JOHN BOLLINGER VIOLA BOWMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET REILLY / DAUGHTER 1717 BAYSIDE DRIVE, CHESTER, MD 21619 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHESAPEAKE^{to}CKEMATION CENTER 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/06/2011 STEVENSVILLE, MD 21. Signal of uperal Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or Immediate Cause (Final Onset and Death poxic Physician/ Respiratory disease or condition resulting in death) Medical Due lo (or as a consequence of) Examiner urrent piration Concentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and I-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Obstructive that initiated events resulting in death) Last Due to (or as a consequence of). burial-1 physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph for use as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year detached 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cancer hung 1 Yes 2 No 3 Probably Wunknown Completed Metastasis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be funeral director 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No မြ 1 Tes Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1-Natural 5 Pending work? Accident Investigation М 2 🗌 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Land Hodical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Lentifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 0 October 5,2011 DD066656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Ctr Dr. Rockville, MD 20850 Faker Oluwapelumi mo 9901 31. Date filed (Month 32. Registrar's Signature 2011 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201^{rg} 9:05P M Frederick Augustus Alles Oct Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Lutheran Healthcare Westminster If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 NT T 8. Date of Birth **Funeral** Hours Director 0°97′0°4′/ 154-22-6976 88 NJ Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State irector 10c. City, Town or Location 10d. Inside City Limits Carroll MD Westminster 1 Yes 2 □ No ā 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 485 Pleasanton Rd. C13 21157 USA 12. Was Decedent Ever in U.S. Armed Forces?,
1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify: White 3 Divorced Completed Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Vice President Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Marshall Alles Arietta B. Ouick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Eva F. Alles- wife 485 Pleasanton Rd. c13 Westminster 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial Cremation 3 Removal from State cemetery, crematory or other place) South Carroll Crem. 10/22/11 4 ☐ Donation 5 ☐ Other (Specify) Winfield 21. Signatury of Juneral Service Licensee 22. Name and Address of FacilityFletcher Funeral Home, chonus T atter 21157 Main St. Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Onset and Death Immediate Cause (Final Physician 10 Unavous Motastatic Brain C disease or condition mer Medical resulting in death) Due to (or as a consequence of) Examiner warred Als Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) the burial-transit noorle Delzeine or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Year n signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page performed? Yes 2 No 1 ☐ Yes 2 ☐ No ours after death.

eral Director: After this certific filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after of Funeral Direc determined 4 Homicide Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Funer completed fil 29b. Signature and title of certifier no completed cause of death (Item 23a) Type, Print) Hereuden Borderchewski IND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieng 33678 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8:30 AM **Physician** 2011 pplina 5 John /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e. Fecility Name (If not institution, give street and number) Examiner MITCHELLVILLE
If Under 24 Hrs. 8. Date of PRINCE GEORGE'S VILLA ROSA NURSING HOME Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex 1 ፟ M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Days Hours NORTH CAROLINA Yrs NOV. 16 1927 84 Director 239-34-2727 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or harm no other traumatic event the servinjury or other traumatic event the serving th 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 □ No PRINCE GEORGE'S SUITLAND MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5000 LYDIANNA LANE # 215 20746 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) IXIYes 2 □ No NAVY fYes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: BLACK 1 ☐ Yes 2 X No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT SUPERVISOR ENGINEER 3rd 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be IDA CURETON ERNEST HOWIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3940 BEXLEY PLACE # 911 SUITLAND, MARYLAND 20746 ARSONIA F. APPLING/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Durial 2 ☐ Cremation 3 ☐ Removal from State 10/24/11 CHELTENHAM, MARYLAND VETERANS CEMETERY 4 Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, early livre. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Dementin Examiner Due to (or as a consequence of): Physiclan/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence ot): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in death) Last 23b. Did tobecco use contribute to the ceuse of deeth? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ thknown 1 ☐ Yes 2 ☐ No Chronic Obstructive Pulmonary þ the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? pheral Vascular Disease 24a. Was an autopsy performed? Be Completed this certificate has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury et Work? After 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1105 F1 realto() 00053337 En 30_Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

Decey MD

31. Date filed (Month, Day, Year)

Smith

Avenue Ste 203 Bultinume, Md 21204

State Registrar

V

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of	of Marylan	•	artment of F tificate of L			giene Reg. No 201	1 33679
Physic	ian/		1. Decedent's Name (First, Middle,	Last)			BRADY		2. Date of De Month	ath Dav Yes	
	dical	ŀ	la. Facility Name (if not institution,	give street and num	nber)		4b. City, Town, or			4c. County of D	Peath
		5	NORTHWEST 5. Social Security Number	Hospina 6. Sex	7. Age (In yrs. Ia	et hirthday)	If Under 1 Year	If Under 24 Hrs			MOKE Birthplace (State or Foreign
Funer Directo	_		213-28-8140	1 □ M 2 XX F	92		Months Days	Hours Min.		Year) 8, 1919 Ma	Country) Lryland
and show	١	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
e Maryl r 28a-f notifie	Director		MD Ball	imore	I	Nottin	gham 10f, Zip Code				1 ☐ Yes 2XXNo
with the s 23a of	Funeral		4412 Vale Drive	è			2123	36		10g. Citizen of What U.S.A	·
Baltimore, Maryland 21215-0036 permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at			1. Marital Status 1. Marital Status 1. Married 2	12. Was Dece Armed Fo 1 Yes If Yes, Giv	edent Ever in U.S proes? 2XXNo /e	l II	Vas Decedent of Hi Yes, specify Cuba	n, Mexican, Puert	pecify Yes or No- to Rican, etc.)	Black, W	omerican Indian, /hite, etc.
21215-0036 within 72 hours after giene. er than "natural", o the Medical Exam	letec			Year or D		16a. Deced	ent's Usual Occup	ation		16b. Kind of Busine	White ess Industry
121; tthin 72 ene. than "	Completed by	<u> </u>	(Specify only higher Elementary/Seconday (0-12) 10th	College (1		life. Do	tind of work done of NOT use retired) Clerical	lunng most of wo	rking	Maryland	State Education
nd 2 filed w tal Hygi d other event, 1	a	3	17. Father's Name (First, Middle, Li					18. Mother's Na	me (First, Middle,	Maiden Surname)	naucaoron
Maryland 2 should be filed lith and Mental Hy 27 is marked oth	P	ъ	William M. Bra 19a. Informant's Name/Relationsh	-		19h Mailin	a Address (Street		Hage1 ural Route Number	r, City or Town, State,	Zin Code)
Mc2 sh lealth ar m 27 is			Theresa M. More			4412	Vale Dr.				
more age 1 a ent of H nt: If ite y or oth		1	20a. Method of Disposition 12		State Ce	emetery, cren	sition (Name of natory or other plac . 1y Cem.		Date /25 /2011	20c. Location - City Holbrook,	
Baltimore, permit, Page 1 and Department of Hea Important: If item any injury or other	il	ŀ	21. Stonature of Funda Service Li		1101	22	. Name and Addres	s of Facility Ec	khardt F	uneral Cha	apel, P.A.
⊞ ₫Δ Ξ α	ōl	+	23a Psyl Enter the disease, or	complications that	caused the death					4.0	ls, MD 21117 Approximate
- Physician	_		shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on ea	ach line.		ARDIAL	INFOR			Interval Between Onset and Death
Medica Examine	_		resulting in death)	Due to	(or as a consequ	ence of):		2010/45	COLAR	DISEASE	UNKHOWN
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Box e death the atte	by Physician/Me		in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		nant at time of d		Ectopic pregnand Other (specify)	У		Month	Day Year
P.O. s that the gned by the e detach	by Ph		Part II. Other significant condition	ns contributing to d	leath but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribut	e to the cause of death?
rds, requires	eted	-									Probably 4 Unknown
/ital Reco sician: The law s certificate has b lirector, page 2 s	Completed	-							24a. Was autor perfo 1 Yes	osy prior deat	e autopsy findings available to completion of cause of h? Yes 2 🗹 No
Division of Vital Records, all or Attending Physician: The law requires s after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be	Be	2	25. Was case referred to medical examiner?	Hospital:			26. Pla	ace of Death (Che		Z NO	165 2 (2110)
of V ug Phys ter this neral dir	te: To		1 Yes 2 No	28a. Date	of injury th, Day, Year)	ER/Outpatien 28b. Time of injury	t 3 DOA 28c. Injury	4 ∐ Nursing F at		dence 6 Other (S)	pecify)
Sion ttendir death. stor: Aff	Certificate:		1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 Could r	ation ot be	of Injury - At hor		M 1 □	Yes 2 No	296 Leasting (Street and Number or	Dural Pauta Number
Divi:			4 ☐ Homicide determi	ned buildi	ng, etc. (Specify)	me, rami, stre	et, factory, office		City or Tow		nural noute Number,
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans	Medical		(Check 2 Medical Ex	caminer: Of the bas	sis of examination	and/or invest	igation, in my opinic	n, death occurred	at the time, date a	use(s) and manner as and place, and due to t e cause(s) and manner	he cause(s) and manner stated.
To the vithir comp	2		29b. Signature and title of certific	7	un		29c. License	number		29d. Date signed (Mo	onth, Day, Year)
۵, ۵		2	30. Name and address of person w	ho completed caus		23a) (Type. P	rint)	10607	5 (urber	22 2011 S MD 21133
15				ued, M	I.D. 5		OLD Co	NET RO	RAND	Ausroun	1 MD 21133
St Regis	ate trar	3	OCT 2 4 2011	Received)	legistrar's Signat	are					

11-07477 William Bennett Jr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

'illiam Bennett, J	1-	State of Maryland / Department of Health and Mental H For State Certificate of Death		2011	33680
Physician		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death
ledical Examine		William Bennett Jr	October 5,	2011	2337 hrs
	2	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat Peninsula Regional Medical Center Salisbury		4c. County of Death Wicomico	
Funeral	5	5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr	s. 8. Date of Birth	n(MM/DD/YYYY) 9. Birth Foreign	place (State or unk
Director		1 Months Days Hours Mir	Sept 6		ntry)
A	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		1-	10d. Inside City Limits
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eath with the Maryland items 23a or 28a-f show	Director	10e. Street and Number UNK 10f. Zip Code	unk 10	g. Citizen of What Coun USA	ry?
	<u> </u>	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S 14. Was Decedent of Hispanic Origin? (S 15. Was Decedent of Hispanic Origin? (S 16. Yes, specify Cuban, Mexican, Puerte	Specify Yes or No- o Rican, etc.)	14. Race - Americ White, etc.	an Indian, Black,
after de	9 -	3 Widowed 4 Divorced If Yes, Give Year 1x Yes 2 No specify:	inali dan I	Specify: wh	ite
MD 21215-0036 nd 2 should be filed within 72 hour slith and Mental Hyggene. num 27 is marked other than "natur numatic event, the Medical Exam To De Commisted		Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)			
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		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or 900 W. Baltimore Str			Zip Code)
		O.C.M.E. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other Specify: in State	Date !	20c. Location - City or	Town, State
Baltimore, permit. Pages 1 ar Department of Her Important: If ite injury or other tr		21. Sign wire of Fune & Service Licensee 22. Name and Address of Facility 32. Name and Address of Facility 33. Name and Address of Facility 34. Sign wire of Fune & Service Licensee 35. Name and Address of Facility 36. State Anatomy Boa 36. Baltimore & MD	rd 655 W	. Baltimore	Street
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Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):			
	<u>ē</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause c.			
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0, be executed sician and burial - transit		UNPENDED AMENDED			
Box 6876C death certificate the attending phys defor use as the b	5	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown			
cords, P.O. law requires that the has been signed by 1.2 should be detached by 1.2 by 1.2 by 1.2 by 1.3 b		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to	
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C# 1 4 2 1 6	tion: T	27. Manner of Death 1 Natural 5 Pending PolyNorm 28a. Date of Injury FOUND: 28b. Time of Injury FOUND: 2145 hrs 28b. Time of Injury 28c. Injury at Work? Pedestrian struck by auto			
Division of Vital Is the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certification filled in by the funeral director.	Certification	2 Accident Investigation Suicide 6 Could not be determined Homicide Homicide Could not be determined Suicide 6 Could not be determined Suicide Homicide Homicide Homicide Homicide Homicide Suicide 6 Could not be determined Suicide Homicide Homicide Homicide Homicide Homicide Suicide Sui			
To the Hosp within 24 ho To the Func completely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)			
To the within To the comp	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	
		Calley C O.C.M.E.		October 6, 2011	
	İ	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	e, MD 21223		
Sta	ate	2 Designatura Cignothyra			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33681 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Brown 1816 Donita 2011 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mayland Medici Center Baltimore 06 5. Social Security Number 212 -02-327 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 DM 2 2 Months Yarvlora Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Baltimore 1 Yes 2 No Maryland 10f. Zip Code 6 10g. Citizen of What Country? Ashbu items 23a USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14. Race - American Indian, Black, White, etc.
Specify: Black 1 Never Married 2 Married þ "natural", or Baltimore, Maryland 21215-0036 lack 1 Yes 2 No Specify: If Yes, Give Year or Dates. 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) student Be 18, Mother's Name (First, Middle, Maiden Surname) Barbara Gaskins 17. Father's Name (First, Middle, Last) ၉ William Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Gaskins Battimore 24 mound 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State andsdown Marylan 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Bleeding Diathesis disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Exam Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant Box 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ate has been signed by the page 2 should be detached P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 X No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b Time of Certificate: 1 Natural 5 Pending 1 Yes 2 🔲 No Accident Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mazur Battimore, mp 22 5 56. Jordan

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2 4 201

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Maryl	-	artment c ertificate c	of Health and N of Death		liene leg. No 20	11	33682
	Physicia	n/	Decedent's Name (First, Middle, Last)	OUISE B	ROWN			2. Date of Dear Month OCTOBEI		2011	3. Time of Death 9:02 P M
	Medic Examin	al	VIRGINIA L 4a. Facility Name (if not institution, give stre		ROWIN	4b. City, Tow	n, or Location of Death	OCTOBE	4c. County		9:02 F W
	į		7404 BELLHAVEN CO				TTSVILLE				ORGE'S
	Funeral Director		228-38-6931	7. Age (In y	s. last birthday)	If Under 1 Y Months Da	Year If Under 24 Hrs. Ays Hours Min.	8. Date of Birth Month, Day, FEB 25	1933	g. Birthp	place (State or Foreign TNIA
	yland f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation				1	0d. Inside City Limits
	ir 28a- notifie	Direc	MD PRINCE GEO	RGE'S H	YATTSVI	LLE 10f. Zip Co	de		10g. Citizen of	What Coun	1X Yes 2 □ No
	with th	Funeral Director	7404 BELLHAVEN COU	RT		2078			USA		
036	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at		11. Marital Status 12 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	U.S. 13	If Yes, specify (of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)		ce - Americ ck, White, o BLA	etc.
21215-0036	72 hour n "natu Aedical	Completed by	15. Decedent's Educa (Specify only highest grade	completed)	(Give	edent's Usual Oc e kind of work do DO NOT use ret	one during most of work	ing	16b. Kind of E	Business Inc	dustry
212	within rgiene. ner tha t, the N		Elementary/Seconday (0-12) 12th	College (1-4 or 5+)			TIVE SUPER			ERNME	NT T
and	be filed sntal Hy ked oth c event	To Be	17. Father's Name (First, Middle, Last) WILLIAM SMITH SR.				18. Mother's Nam		Maiden Surnam	re)	
Mary	2 should th and Mi 27 is mar traumati	4	19a. Informant's Name/Relationship (Type, LISA MARTIN/DGT.	Print)	19b. Mai	iling Address (St.	reet and Number or Rur CHIO LANE CA	al Route Number APITOL H	City or Town,	State, Zip (Code) LAND 20743
Baltimore,	Page 1 and ment of Heal ant: If item 3 ury or other		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	mouel from State	cemetery, cr	position (Name cematory or other	r place) 10/2 RCH CEME.		20c. Location	CEVIL	LE, VIRGINIA
LAWRENCEV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 24. LANDOVER ROAD HYATTSVILLE, MARY										ARYLAI	ND 20785
and .	Medical	200	23a. Part 1 Enter the disease, or complice shock of heart Jailure. List only one of Immediate Cause (Final disease or condition resulting in death)	titions that caused the cause on each line. PANCREATION Due to (or as a cons	C CANCE		dying, such as cardiac	or respiratory arm	est,		Approximate Interval Between Onset and Death 4 MONTHS
مبد	Examiner	-i-	Sequentially list conditions, b.								
	uted Id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events C.								
0	icate be executed physician and s the burial-transit	edical Ex	resulting in death) Last	Due to (or as a con:	sequence of):						
38760	rtificate ling physe as the	/Medi	IF FEMALE:	. If yes, outcome of pre	anancy						
. Box 68	ne death certificate be executed the attending physician and ched for use as the burial-transi	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 Live Birth 2 4 Pregnant at time	Fetal death 3	☐ Ectopic preg ☐ Other (speci				ate of deliv	ery Day Year
s, P.O.	law requires that the de nas been signed by the. e.2 should be detached	by	Part II. Other significant conditions contr	ibuting to death but no	t resulting in the	e underlying caus	se given in Part I.				ne cause of death?
Division of Vital Records,	aw as	Completed						24a. Was a autop perfo	sy	prior to co	psy findings available impletion of cause of
<u>=</u>	hysician: The lar nis certificate ha I director, page 2	Be Co	25. Was case referred to medical			2	26. Place of Death (Chec	1 Yes	2X No	1 Yes	2. No
Z Z	Physici this cer al direc	은	1 L Yes 2 X No	1 Inpatient 2	2 ER/Outpat			ome 5 Resid)
o u	ath. : After e funera	icate	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Yea			Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occui	rea	
Division	To the Hospital or Attending Physician: The I within 4 below a feet death. To the Funeral Director, After this certificate h completed filled in by the funeral director, page	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.		street, factory, of	ffice	28f. Location (S City or Tow		ber or Rura	l Route Number,
_	e Hospita 24 hours e Funera bleted fille	Medical	29a. Certifier 1 X Certifying Physici (Check 2 Medical Examiner only one) 3 Certifying Nurse F	On the basis of examin	ation and/or inv	estigation, in my	opinion, death occurred a	at the time, date a	nd place, and d	ue to the ca	use(s) and manner stated.
_	Verthii Verthii Voomp	-	29b. Signature and title of certifier			29c. Li	cense number		29d. Date sign	ed (Month,	Day, Year)
	68h		30. Name and address of person who com	pleted cause of death	(Item 23a) (Type	, Print)		TTA 0000			
	Sta	te	JACOB NINAN M.D. 4	320 SEMINA		ALEXAN	DKIA, VIRGII	NIA 223U	4		
	Registr		31. Date filed (Month Day Year) 0 1 2 4 201	1 anun	1. 4	Jarkel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Worth tober 182011 JUNE BEVERLY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DOCTOR'S HOSPITAL LANHAM PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗓 F Director 577-48-0209 JUNE WASHINGTON, DC 5 1934 Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director 1 XYes 2 No MD PRINCE GEORGE'S UPPER MARLBORO 10f. Zip Code 10g. Citizen of What Country? Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a on ther traumatic event, the Medical Examiner must be. 13105 WATER FOWL WAY 20774 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. BLACK Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 1+ADMINISTRAVE ASSISTANT PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ EARL WILSON LUTRICIA JEFFRIES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KIM BEVERLY/DGT 13105 WATER FOWL WAY UPPER MARLBORO, MARYLAND 20774 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN CEMETERY 10-24-11 SUITLAND, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death metasta tic Immediate Cause (Final wer cer Madder Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Sers: S **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🔀 No Month Veal Day ned by the a 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy funeral director, page 2 performed? death? 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: ၀ 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 🛣 Natural 5 Pending Investigation Accident 24 hours after deat Funeral Director; 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Image: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. I musemil Abdella, mo D0059981 (Type, Print)
12200 AUNAPOLIS ROAD SUITE 259 GLENNDALE
MD 20749 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mukemil Abdella, m.D 31. Date filed (Month, Day, Year) State 24 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First_Middle_Last) 2. Date of Death Physician/ Month Mildred Bass 19 2011 :10P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore 8. Date of Birth (Month, Day, Year) Feb. 16,1931 If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Davs Hours Director 217-24-1484 1 M 2 F 80 MD Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f MD 1 X Yes 2 No Baltimore 10e. Street and Number 5 10g. Citizen of What Country? Examiner must be Funeral 23a 2436 E. permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If fern 27 is marked other than "any injury or other traumair. Lafayette Ave. 21213 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Bace - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify:[JSA Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Woodrum Mary Epps ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilbur Cooper (son) 106 Kenilworth Ave. Apt lA Balto, Md. 21204 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Mem.Pk Oct.28.2011 Arbutus Balto Md e Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home Preston 21213 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line le death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Due to for as a consequence on if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events the burial-trar Due to (or as a consequence of): ш resulting in death) Last attending physician Physician/Medical certificate be Box 68760 as IF FEMALE nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown signed by the atte Month Day Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires to 24 hours after death.
 Funeral Director: After this certificate has been sign 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital DL 40 မ 1 Yes 4 Nursing Home 5 Residence (2) Other (Specific 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending iniury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 To the I within 2 only one 29d. Date signed (Month, Day, Year)
CESTOSEP 19 2011 29b. Signaty 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles LES MO 6701 N 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2 1 2011 Registrar

11-07908 Zoev Crumpton Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

oey Crumpton	State of Maryland / Department of Health and Internal Hygierie 1- For State Certificate of Death Reg. No. 20 33685
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 2.314 bro
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Hospital 4c. County of Death Baltimore
Funeral Director	5. Social Security Number 212 39 2188 6. Sex 1. Months Days Hours Min. Feb. 26, 1993 7. Age (In yrs. last birthday) Months Days Hours Min. Feb. 26, 1993 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Maryland Country)
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
B	Maryland Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
n the Maryland 3a or 28a-f she otified at once	
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 23a-f sho reat, the Medical Examiner must be notified at once Be Completed by Funeral Director	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced of Pates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No specify: 1 Yes 2 No specify: 1 Yes 2 No specify: 1 Yes 2 No specify: 1 Yes 2 No specify: 1 Yes 2 No specify:
5-0036 ed within 72 hours afth Tygiene, other than "natural" the Medical Examine Completed by	45. Becades the Education (Specific only highest grade campleted). 16a. Decedent's Usual Occupation (Give kind of work done. 16b. Kind of Business/Industry
215-003 be filed withintal Hygiene, rked other thent, the Med	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rita Michele Jowanowitch
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medical To Be Comple	19a. Informant's Name/Relationship (Type, Print) Rita Michele Keifer (Mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 South Clinton St. Baltimore, Maryland 21224
Baltimore, MD 212 permit. Pages I and 2 should by Department of Health and Ment Important: If item 27 is mark injury or other traumarite ever	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory Inc. 10/27/2011 Baltimore, Maryland
	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex, Maryland 21221 23. Part February arrest, shock, or heart Approximate Interval
Physician Medi- Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Blunt Force Injuries Between Onset and Death
	Sequentially list conditions, b.
ted Insit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated country the country in a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
and transit	events resulting in death) Last Due to (or as a consequence of). d.
50, te be executed sysician and burial - transit	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
ox 6876 eath certifica attending ph for use as the	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown Month Day Year
P.O. Es that the company and by the detached by the by Physical Ph	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transimedical Certification: To Be Completed by Physician/Medical Expedical	24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Reician: The certificat rector, pa	25. Was case referred to medical
of Vid g Physic fter this neral dire	1 Ves 2 No Page of Death 28a Date of Injury 28b, Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
Division o spital or Attending sours after death. neral Director: Aft filled in by the func Certification:	1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Di To the Hospital within 24 hours a To the Funeral completely filled	
To the Ho within 24 To the Fu Completel	29b. Signature, and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	O.C.M.E. October 21, 2011
	30. Name and address of person who complete it use of death (Item 3a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
Stat Registra	

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #28e&f Per ME G920 10 24 2011 JH State of Maryland / Department of Health and Mental Hygiene Company of the Index of Maryland / Department of Health and Mental Hygiene Company of the Index of Maryland / Department of Health and Mental Hygiene Company of the Index of Maryland / Department of Health and Mental Hygiene Company of the Index State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2DI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, **Examiner** Town, or Location of Death 4c. County of Death SMOVE If Under 24 Hrs. 8. Date of Birth
(Month, Day, Y)
July 24, Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In vrs. last birthday If Under 1 Year Days Min 1 ▼ M 2 □ 265-15-7944 58 Director Yrs. Usual Residence of Decedent or 28a-f show unk 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at **Funeral Director** FI 1 Tes 2 X No 0akhi11 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a 109 Center Street 32759 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, unk Black, White, etc 0 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Completed by Baltimore, Maryland 21215-0036 unk 1 Yes 2 No Specify: white "natural", Specify. 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation unk 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ည other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) University of MD Shock Trauma 22 S. Greene Street Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ö injury 4 □ Donation 5 🗓 Other (Specify) in state permit. Ronal 1 Director any inj Signati State and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1 shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Ulmora disease or conditi-resulting in death) Medical Due to (or as a consequence of): Examiner iceanula 5 squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury LEFTIFICATION APPROVED BY MEDICAL EXAMINER Examine Due to (or as a consequence of) the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records. P.O. Box 68760 inding i for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy atter Day Month Pregnant at time of death 5 Other (specify) Year ed by the a 9 Unknown 9 I Inknown s been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an cate has b autopsy performed? certificate ! Yes Be 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Other: 4 \(\triangle \) Nursing Home 5 \(\triangle \) Residence 6 \(\triangle \) Other (Specify) Hospital: 1 ♣ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 0351AM Natural Accident 5 Pending 10/11 Investigation truck ariver 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, fac building, etc. (Specify) Roadway factory, office 28f. Location (St. et and Number of Rural Route Number, City or BAN SELVITTE MF. SQUAR, 13222 Ban celette Road MF. SQUAR, 4 Homicide filled in by determined VWKNO Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hc

To the Fune

completed t (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one 3 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) 10/17 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Muchinitha SANdrA VEENC

State

Registrar

31. Date filed

Year 4 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

33687

Ismael Mejia Cosm	1	- For State Registrar	State	of Maryla	nd / Depa <i>Cer</i>	rtment of tificate of		and	Mental Hy		Reg. No	201	1	3368
Physician/ Medical Examine	1	Decedent's Name (Fig. 1)	st, Middle,Las		EL MEJIA	COSME				2. Date of Dea Month October 1		Year 011		Time of Death 0713 hrs
	ľ	4a. Facility Name (if not Prince George's		e street and nu	mber)		4b. City, Towr Cheverly	,	cation of Death			c. County of Dea Prince Georg	ge's	
Funeral Director	1	5. Social Security Numb		эх ZM 2F	7. Age (In yrs. la	st birthday) 60 Yrs		Year Days	If Under 24Hrs. Hours Min.	8. Date of Bi				ace (State or Foreign Lvador
ow any	_	Usual Residence of Dec 10a. State 10b.	County			Town or Locat			•			10d. Inside City Limit		
eath with the Maryland items 23a or 28a-f show ust be notified at once.		MD P1 10e. Street and Number 4711 66th		GEORGES	HYAT	TSVILL	10f. Zip Coo		0784		J	itizen of What Co		?
p	3	11. Marital Status 1 Never Married 3 Widowed		Armed Fo	2 X No	If Y	es, specify Co	of Hispa uban, N	anic Origin? (Sp Mexican, Puerto specify: Salv	ecify Yes or N Rican, etc.)	0-	14. Race - Am White, etc.	erican	
5-0036 ed within 72 hours aft tygiene. other than "natural" the Medical Examine Completed by		15. Decedent's Educar Elementary/Seconda	tion (Specify o	or Dates:	de completed)	16a. Deceder during m	nt's Usual Occ	upatio	n (Give kind of w	ork done	16b.	Kind of Busines	ss/Indu	stry
21215-0036 uld be filed within 7 Mental Hygiene, marked other than c event, the Medica	3	17. Father's Name (Firs		RAFAE	L COSME				Mother's Name	EJIA	Maide	n Surname)		
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Baltimore, pernit. Pages I at Department of Hee Important: If ite		1 Burial 2 0 4 Donation 5 21. Signalure of Funera	Other Specify	. <u> </u>	om State Mun	22.1	name and Add	que dress o	f Facility Sat	nta Cri	ız F	Funeral	Ser	vices,Inc
Physician /Medical -xaminer		23a. In t. Enter the dis failure. List only on Immediate Cause (Fina or condition resulting in Sequentially list conditi if any, leading to immed	ne cause on e. I disease a. death) b. ons,	Atheroscle	aused the death. rotic Cardiov	Do not enter t ascular Dis	he mode of dy	-			-	hock, or heart	1	Approximate Interval Between Onset and Death
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ing Physician: The law requires that the death certificate be executed fines Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and finneral director, page 2 should be detached for use as the burial - transit To Be Commoleted by Physician/Medical Exp	2	UNPENDED IF FEMALE: 3b. Was decedent pregpast 12 months? 1 Yes 2 No 9	Unknow	1 Live b 4 Pregr	nant at time of de	2 Fe ath 5 0	etal death ther <i>(Specify)</i>		Ectopic pregna		i de	23d. Date of delive Month	Day	
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of Vital Records, Ing Physician: The law requires the this certificate has been signered director, page 2 should be not To Be Completed		25. Was case referred t		Lines italy					of Death (Check	1 Yes	formed 2	? death	Yes	2 No
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Division o Division o Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: All completely filled in by the fune		2 Accident 3 Suicide 6 4 Homicide 29a. Certifier	determine	28e. Placed (Specify)	e of Injury - At ho					or Town,	State)			Route Number, City
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OCME		30. Name and ad ress Zabrullah Ali, M	of p son w o	completed cau	ARYG.Anse of death (Item	23a)		C.M Stree		MD 21223		ctober 14, 20	011	
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Christello Mq 00:8 Frances M. 2011 October Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cecil North East 66 White Birch Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours Min 1 M 2 X F 192-07-1911 100 Pennsylvania **Director** September 6,1911 Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location the Medical Examiner must be notified at **Funeral Director** Baltimore Dundalk Md. 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21222 1902 Madison Road USA or items filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White Specify: If Yes, Give "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife 6 years Be other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F 7 is marked of t. Page 1 and 2 should be fill tment of Health and Mental rtant: If item 27 is marked o ျှ Michael Cristillo Theresa D'Aprile 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 66 White Birch Drive, North East Md. 21901 Dominick J. Christello Jr. Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 9 = P October cemetery, crematory or other place) 1🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State permit. Page Department of Important: If any injury or Dundalk, Maryland St. Stanislaus Cem. 24, 2011 Other (Specify) 4 🗌 Donation eral Service 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. ture of lign 7110 Sollers Point Road, Dundalk, Md. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ementia Physician/ Vascular disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence or): Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Day Year Month Yes 2 No 1 | Yes 2 | 9 | Unknown been signed by the should be detached g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Heart 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA ieral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending 1 X Natural Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/20/2011 Below 100 o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

State Registrar ISE

31. Date filed (Month, Day, Year)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIEM# I perphys, 6920, 10724, 2011, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Celia D. Darby 201 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Street Baltimore 1508 N. Eden Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Mar. 12, Year 937 Months Days Hours Min. 1 M 2 F VA. 74 **Director** 216-34-3344 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b Funeral USA 21213 1508 N. Eden St. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Representative Retail Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Gamaiel Darby မ Ella Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Tayun, States Zip Code) ISUS N. Eden St. Balto, Md. 21213 Charles E. Hurt 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o **X**☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct.20,2011 Mt. Balto, Md. 4 Donation Other (Specify) Zion Cem. ture of Funer Service Licensee Call and Address of Facility ruggs Funeral Home Preston St. Balto, Md. 21213 1412 Ε 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Securitish list nanditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Day sate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 316172 autopsy perform death? Yes the Hospital or Attending Physician: To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No after death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1-love strar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 17 2011 i MICHAEL ANTHONY **EDWARDS** SR. 10:34 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S 3940 BEXLEY PLACE TEMPLE HILLS If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Min 1 XM 2 □ F Hours FEB. 26 1944 WASHINGTON, DC Director 67 579-56-9629 Usual Residence of Decedent 10b. County 10a. State 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No MD PRINCE GEORGE'S TEMPLE HILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20748 USA 3940 BEXLEY PLACE . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the N SANITATION WORKER DC GOVERNMENT 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Page 1 and 2 should be WILLIAM EDWARDS UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27406 19a. Informant's Name/Relationship (Type, Print) 203 OLD TREYBROOK DRIVE GREENSBORO, NORTH CAROLINA MARION WILLIAMSON/DGT. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If its any Injury or of 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10-25-2011 SUITLAND LINCOLN CEMETERY : .MARYLAND 21. Signature of Funera Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or feart failure. List only one cause on each line. Approximate shock, or beart failu Immediate Cause (Final Interval Between Onset and Death Physician/ disease or condition resulting in death) HYPERTENSION Medical Due to (or as a consequence of) Examiner CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami sician and burial-transit CARDIOVASCULAR DISEASE that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical death certificate be MORBIT OBESITY as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Day Pregnant at time of death Other (specify) is certificate has been signed by the a director, page 2 should be detached 1 L Yes 2 L 9 L Unknown q | Unknown ivision of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? After this certificate 1 Yes 2 No Yes 2 Tr No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ျာ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completed filled in by the funeral 27. Manner of Death 1 XNatural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation
6 Could not be To the Hospital or Attendenthin 24 hours after deat To the Funeral Director: 3 Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar 29b. Signature and title of certifier

H elsen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HASSAN BUSHEHRI M.D 31. Date filed (Month, Day, Year)

MI)

1328 SOUTHERN AVENUE SE # 201 WASHINGTON, DC 20032

29d. Date signed (Month, Day, Year)

21.

10.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 2 Day Physician/ 0523AM 2011 William Medical Bernard 4a. Facility Name (if not institution, give street and numbe 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Rosedale FAANKLIN Square Ltimore HOSPITal 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1**X** M 2 □ F Hours 6/4/1929 (Par) Maryland Director 82 217-24-0787 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any iniury or other traumatic event, the Medical Examiner must be a Funeral 504 Tidewater Lane S. Α 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? orces: 2 No 1947 Black, White, etc. 1 Never Married 2 Married þ 1 XYes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 🗆 Widowed 4 🗆 Divorced Completed White Year or Dates 1968 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) / Operator Restaurant Owner Be pe filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Barbara Zillich Frank Fraer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 si tment of Health a Donna Marie Marin (Daughter) 202 Commodore Drive Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue Signature of Funeral Service Licensee Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician) Myscardial disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury droxarya use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No Division of Vital Records, 1 Yes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director; After this certificate has autopsy perform page 2 1 Yes 2 🗌 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be funeral director, 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 5 Pending Accident Investigation completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I ignature 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland		artment of He tificate of De			7111	1 33692
			Registrar 1. Decedent's Name (First, Middle, Last)	007	imouto or be	Jan	2. Date of Deat		3. Time of Death
	Physicia Medic		Freida Frazier				Month Octobe		
	Examin	er	4a. Facility Name (if not institution, give street and number) St, Joseph Hospital		4b. City, Town, or Lo	ocation of Death		4c. County	of Death 1timore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth	<u> </u>	Birthplace (State or Foreign Country)
	Director		212-24-9389 1 □ M 2 🗓 F 93 Usual Residence of Decedent	Yrs.	Worlding Baye	, rodio	July 30	, 1918	Maryland
	and show dat	tor	10a. State 10b. County 10c. City, 7	own or Loc	cation				10d. Inside City Limits
	Mary 28a-f	Director	MD Baltimore	Tows					1 X Yes 2 No
	vith the	ral	7001 N. Charles Street		10f. Zip Code	204	1	0g. Citizen of W	SA
	death v items ier mu	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hisp Yes, specify Cuban,	anic Origin? (Spe	cify Yes or No-	14. Race	- American Indian,
980	rs after o iral", or i Examin	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	- 1	☐ Yes 2 🎇 No		tiouri, oto.,	Specify:	k, White, etc. black
Maryland 21215-0036	n 72 hou an "natu Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give F	lent's Usual Occupati kind of work done dur O NOT use retired)		ng	16b. Kind of Bu	siness/Industry
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and	be filed ental H ked ot c ever	To B	17. Father's Name (First, Middle, Last) Spencer Hack		1	8. Mother's Name	e (First, Middle, N Tulia Co)
ary	should be file and Mental I is marked o raumatic eve	10	19a. Informant's Name/Relationship (Type, Print)		g Address (Street and	d Number or Rura	l Route Number,	City or Town, St	tate, Zip Code)
Σ,	and 2 s Health Pm 27		Sharon Evans/goddaughter		Sheridan				21212
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in State	netery, cren	sition (Name of natory or other place)		Date	20c. Location -	City or Town, State
Balt	permit. Depart Import any inj	1	21. Signature Funeral Service Licensee Bound S Wade Director		Name and Address tate Anato altimore,	of Facility Dmy Board MD 2120	1 655 W.	Baltim	ore Street
Т			23a. Part 1. Ener the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.			such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death
>- Pring.	Medical		Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequer	200 of					Days
hard.	Examiner			,	maki an				Davs
	p ta	niner	Sequentially list conditions, b. Myocardial cause. Enter Underlying	ice oil.					
	xecute n and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Alzheimer's Due to (or as a consequer	Den nce of):	<u>lentia</u>				Years
09	e be e iysiciar ne buri	dical	d						
9876	ertificat ding ph	/Mec	IF FEMALE: 23b. Was decoded transport 23c. If yes, outcome of pregnance	v				201 5-1	
P.O. Box 687	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	leath 3	Ectopic pregnancy Other (specify)			Moi	e of delivery nth Day Year
P.O.	that the	by Ph	Part II. Other significant conditions contributing to death but not result	ing in the u	nderlying cause giver	n in Part I.	23e, Did tol		ibute to the cause of death?
rds,	equires een sig nould b	ted	<u> </u>				1 🗆 Y		3 Probably 4 Unknown
Division of Vital Records,	2 55 %	Somple					24a. Was a autops perform	ned?	Were autopsy findings available prior to completion of cause of death?
ta	ician: certifica rector,	Be	25. Was case referred to medical examiner?		Louis	e of Death (Check			
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on	eath. or: Afte the fun	Certificate:	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be	injury	M 1 ☐ Ye	es 2 🗆 No			
Divis	al or Att s after d al Direct ed in by		4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (St City or Town		er or Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier (Check only one) 1	nd/or invest	tigation, in my opinion,	, death occurred at	the time, date an	d place, and due	to the cause(s) and manner stated.
	To the within congression	_	29b. Signature and title of certifier		29c. License n	13464	2	9d. Date signed	(Month, Day, Year)
	,		30. Name and address of person who completed cause of death (Item 2			Погласт	M ~ ~ ~ ~ 1	-/'/	1204
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signatur	sier	Drive	Towson	, mary	and Z	1204
	Registr	ar	OCT 2 4 2011 Denny P. 19	10 m					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of I <i>rtificate of I</i>			giene 0		33693	
ı	Physicia		Decedent's Name (First, Middle, Last)		lizabeth	Colbert	Gibson	2. Date of Dea Month	ath Day	Year	3. Time of Death	
	Medic Examin		4a. Facility Name (if not institution, give s				r Location of Death	10		2011 ty of Death	10:45 A M	
			Blue Point Nursi				timore					
	Funeral Director		5. Social Security Number 6. Sex 1 C	7. Age	(In yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 01/23/	1956	9. Birthp Count Mary	lace (State or Foreign land	
	how at	ř	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits	
	Aarylar 8a-f sl tified	Director	MD			Baltimor	e				1 X Yes 2 □ No	
	vith the N 23a or 2 st be no		10e. Street and Number 411 N. Collingto	n Avenue		10f. Zip Code 21	231		10g. Citizen of	What Coun	try?	
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentell Hygiene. If health and Mentell Hygiene. A great Z is marked other than "ratural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ★ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🛣 N If Yes, Give	No.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ice - Americ ack, White, e	etc.	
9	hours natura fical Ex	letec	3 Widowed 4 Divorced 15. Decedent's Edu			dent's Usual Occup			16b. Kind of I			
Maryland 21215-0036	ithin 72 ene. • than "i the Med	Completed	(Specify only highest grade Elementary/Seconday (0-12) 12th	e completed) College (1-4 or 5+	life I	kind of work done NOT use retired) Homemake		king	Priv	vate		
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ryla	should be file n and Mental H 7 is marked o raumatic eve	Τo	Charles Colbert 19a. Informant's Name/Relationship (Typ		1			Louise			N	
	and 2 sho Health an tem 27 is other trau		Christine Kelly		19b. Maii 411	N. Collir	and Number or Run ngton Ave	nue, Bal	timore	MD 21	231	
>	Page 1 alment of H ant: If iter		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		1	osition (Name of matory or other place Cremation		Date 25/2011	20c. Location	-		
Baltimore,	permit. Page 1 Department of Important: If i any injury or conce.		21. Signature of Funeral Service License		2	2. Name and Addre	ess of Facility La	timore F	uneral	Servi	ces, P.A.	
2818 E. Baltimore Street, Bal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between		
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	1 🗸		30. Name and address of person who co Karen Merritt, M	·	ath (Item 23a) (Type, Smith Ave		- 203 P	altimore	MD 211	200		
	Stat Registra		31. Date filed (Month, Day, Year) OCT 2 4 201	32. egictrar			E 203, D	TTCTIIOT 6	. LID (112	202		

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			For State Registrar	State of Ma	aryland		epartme C <i>ertifica</i>			Mental Hy	/giene Reg. Ne	0 1	1	33694
			Registrar Decedent's Name (First, Middle, La.	st)			Crunca	10 01	Death	2. Date of De		_ U 1	•	3. Time of Death
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	ryland how		10a. State 10b. County				r Location						100	d. Inside City Limits
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21215-0036	172 hours after death with the Maryland "natural", or items 23a or 28a-f show dical Exa inver must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		o.	15. Was Dec If Yes, sp 1 ☐ Yes		dispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)	0-	Black, V Specify:		c.
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Maryland	2 should be f and Mental I Is marked of raumatic eve	ဥ	19a. Informant's Name/Relationship (Type. Print)		19b. N	Mailing Addres	ss (Street	and Number or Ri	ıral Route Numi	ber, City o	er Town, Sta	ite. Zip (Code)
	alth a 27 Is		Mary Ella Gephard	t (Daughte	er)		-		ourt, Bal		-			
J.e.	es 1 a of He item	1	20a. Method of Disposition		20b. PI	ace of D	isposition (Na	ame of other plac	ce)	Date	20c. Lo	ocation - City	y or Tow	n, State
Ē	Pag ment ant: I	Elementary/Secondary (0-12) 8 College (1-4or 5+) School Bus Driver 17. Father's Name (First, Middle, Last) Raymond Kelly 19a. Informant's Name/Relationship (Type. Print) Mary Ella Gephardt (Daughter) 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Elementary/Secondary (0-12) 8 College (1-4or 5+) School Bus Driver 18. Mother's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Rolling) 19c. Mary Ella Gephardt (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 10/18/2 21. Signature of Funeral Service Licensee								18/2011	Bal	e, M	Maryland	
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdziński Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 2											
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of	Physician: The ribis certificate h ral director, page		1 ☐ Yes 2 ☑ No 27. Manney of Death	Hospital: 1 Inpatie		ER/Outp	atient 3 🔲 [4 LI Nursing F	lome 5 ☐ Res			(Specify))
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ĕ	al or s afte al Dire	Certification: To	4 ☐ Homicide determined	building, etc	. (Specify	"				City or 1c	iwn, State)		
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Ph	ysician: To the best on niner: On the basis of and manner sta	of my knov examinat ted.	vledge, o ion and/	death occurre or investigation	d at the ti	me, date and plac opinion, death occi	e, and due to th urred at the time	e cause(s e, date and) and mann i place, and	er as sta due to	ated. the cause(s)
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33695 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <u>A</u>M ^M Cecil W. Gardner October 2011 3:55 Medical 4a. Facility Name (if not institution, give street and number) 4h City Town or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Towson Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Min **Director** 212-42-6613 1 X M 2 - F 72 July 11, 1939 Usual Residence of Decedent Maryland or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City. Town or Location Director 1 Yes 2 No MD Baltimore Baltimore o 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 6450 Falkirk Road #C 21286 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or ò 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: white 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumans. analyst US Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cecil Hall Gardner Ruth Elizabeth Work 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathryn A. Gardner/spouse 6450 Falkirk Road #C Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🗎 Cremation 3 🗌 Removal from State 4 X Donation 5 ☐ Other (Specify) r Funeral Service Ronald State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Darector Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) YELVY Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine cause. Enter Underlying Due to for as a so issurer se on Cause (Disease or injury for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 1 Lyes 2 L 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Dunknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page 2 No this certificate 1 Yes 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year

101

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UHANKI

2 4 201

Octoben 17 2011

(+ TOWSON MM)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Perate Hi (2) Jane 15 20 The Hof Health and Mental Hygiene 33596

	1	State Amend Item 21 Registrar	l per in,gy	20,10/24/ Ce	rtificate of	f Death			Reg. N	2011	33030
Physician/	_	1. Decedent's Name (First, Middle, Las						2. Date of De Month		ay Year	3. Time of Death
Medical	1	Bernard Neal	Henry		Ab. Oib. Tours	e-Leasting	of Dooth	August		7, 2011 c. County of Deat	12:57 a ^M
Examiner	1	la. Facility Name (if not institution, give	street and number)		4b. City, Town Balti		or Death		40	. County of Deat	
Funeral Director	5	Sand Septing Number 5 220 20 9105 Usual Residence of Decedent	ex 7. Age (I	n yrs. last birthday) 7 Yrs.	If Under 1 Yes		Min.	8. Date of Bir (Month, Da 02/25/	y, Year)	Co	hplace (State or Foreign untry) ryland
or 28a-f shov notified at	IOLOG	Oa. State 10b. County	1	Oc. City, Town or Lo							10d. Inside City Limits 1 X Yes 2 □ No
leath with the Mitems 23a or 20 ler must be not Elmoral Dir		Oe. Street and Number 1927 Harlem Ave	enue	`	10f. Zip Cod 2121					itizen of What Co	untry?
S F E	3	1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.		Was Decedent of If Yes, specify Co	uban, Mexic	an, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify: B	
215-C	najaidiiion	15. Decedent's E (Specify only highest gn Elementary/Secondary (0-12)		(Give life, D	dent's Usual Occ kind of work dor OO NOT use retire	ne during mo	st of work	king		Kind of Business	Industry
and 21 oe filed with mula Hygier ced other t c event, th	2 1	9th 17. Father's Name (First, Middle, Last) Harley Henry		, KO	oter		ther's Nam	ne (First, Middle,			
Maryle should b and Mer 7 is mark raumatic	-	19a. Informant's Name/Relationship (7	ype, Print) ry – wife	F		eet and Num	ber or Rur	al Route Numbe		or Town, State, Zij	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Examples. To Re Commission by	-	20a. Method of Disposition 1	Removal from State	20b. Place of Dispo	osition (Name of matory or other p			Date 2/2011	20c. I	, MD 212 _ocation - City or altimore	Town, State
Baltir permit. P Departme Importar any injur		21. Signature of Funeral Service Licent Dietrich N. 1	see	er DVR	2. Name and Ad PA , 2140	dress of Fac N. Fu	ility Jo Lton	seph H. Ave.,Ba	Bro 1tir	own Jr. nore,MD	Funeral Home 21217
Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	one cause on each line.	onse uence of):	er the mode of co	dying, such a	s cardiac	or respiratory ar	rrest,		Approximate Interval Between Onset and Death
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law equires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has I een signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate. To Be Completed by Physician/Medical Examiner	Sulcal Exami	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a c	onsequence of):							
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law equires that the death certification the Funeral Director After this certificate has Leen signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certificate. To Re Completed by Physician/M.		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Who 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	☐ Ectopic pregn☐ Other (specify					23d. Date of de Month	livery Day Year
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Division of Vital Records, P.O. Box lat or Attending Physician. The law equires that the death or stafter death. In Director, After this certificate has I een signed by the attented in by the funeral director, page 2 should be detached for uncertificate. To Re Commission Physician	aldillo	antery disea	H					24a. Was auto perfe 1 Yes	psy ormed?	prior to death?	atopsy findings available completion of cause of s 2 \square\$ No
cian: T		25. Was case referred to medical examiner?	Hospital:			. Place of D		ck only one)			
Physic Physic This c		1 Yes 2 No 27. Manner of Death		t 2 ER/Outpatie	ent 3 □ DOA	Other: 4 njury at	Nursing H	ome 5 Resi	idence	6 Other (Spec	city) MOSIPI 4
nding ath. :: After e fune		1 Natural 5 Pending 2 Accident Investigatio	(Month, Day,)		V	ork?	□ No	200. 20001150	11011 11110	ny obbanica	
Division of all or Attending P a after death. Il Director: After t ad in by the funer.		3 ☐ Suicide 6 ☐ Could not be determined		- At home, farm, st Specify)	reet, factory, offi	се		28f. Location (City or To			ıral Route Number,
he Hospita in 24 hours he Funeral pletely filled	Medica	(Check 2 Medical Exam	sician: To the best of miner: On the basis of example Practitioner: To the basis of	mination and/or inves	stigation, in my o	oinion, death	occurred a	at the time, date	and plac	e, and due to the	cause(s) and manner state
To t To t	1	29b. Signature and title of certifier	NUD		29c. Lice	ense number	30	3		rate signed (Mont	
		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type,	6701	N.	Ch	nces s	T	Tans	20 2011 0N MD
State Registrar		31. Date filed (<i>Month, Day, Year</i>) OCT 2 4 2011	32. Registrar's	Signature . Apar	les .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10-19-2019ay 6 .15.a. M Theresa L. Herbert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred HeartHome INC Hyattsville PG 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 1 □ M 2 🔀 F Days Hours Min. 579-42-3094 Director 18 1930 Usual Residence of Decedent r 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County death with the Maryland 10c. City. Town or Location Director 1 XYes 2 No MD Bowie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö ms 23a or must be n Funeral 20715 2316 Kemmerton Ln items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 0 þ 1 Never Married 2 Married Yes 2 XI Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify. If Yes, Give Year or Dates SpecifyBlack "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Government Data Clerk 12th permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dudley Herbert Ida Barber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Herbert/Son 12316 Kemmerton Ln. Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Alexandria,VA 10-25-2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Murray Funeral Home 722 N. Capitol St. NW Washington, DC 20001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) a. Myocardial Infarction
Due to (or as a consequence of): Medical Examiner Chronic Renal Failure Sequentially flat nonditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Chornic Liver Failure To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hypertension Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Psychosis 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 1 Yes 2 No this certificate 1 ☐ Yes 2 ▼ No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Be examiner? Hospital 2 🔀 No Other: 1 🗌 Yes ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 XNursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury 28b. Time of s after death. Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

30. Name and address of person who Ramen Rekha Tuli

31. Date filed (Month, Day, Year)

2 4 2011

arka

Hvattsville MD

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

5805 Oueens Chapel Rd

10-19-2011

			For State	State of Ma	ryland		irtment of F tificate of I				giene _{Reg. N} 2	011	33	698
			Registrar 1. Decedent's Name (First, Middle, Las	")					2.	Date of Dea		Year	3. Tim	e of Death
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	Examin		4a. Facility Name (If not institution, give	,			4b. City, Town, or		of Death		4c. 0	County of Dea	ath	
#76.00	Funeral	-	Johns Hopkins Bayvie 5. Social Security Number 6. Se	x 7. Age		st birthday)	Baltimore If Under 1 Year	If Unde		Date of Birt	h Year)	9. Bi	rthplace (Sta	te or Foreign
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	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Insid	e City Limits
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	or 28%	Direc	10e. Street and Number				10f. Zip-Code				_	en of What C	ountry?	
	s 23a	Funeral Director	19 Midway Avenue	40 Mar Danielani E	in II C	110.1	2122		rigin? (Specifi	. Von or No		J.S.A.	erican Indiar	
٥	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at nt, the Medical Examiner		11. Marital Status 1 ☐ Never Married 2 💆 Married	12. Was Decedent E Armed Forces? 1 Yes 2 X			Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 XNo			an, etc.)		Black, Whi	te, etc.	1,
2-003p	ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:				Specify	/. 			Specify:	White	
ה	n 72 h "natu edical	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	lent's Usual Occup kind of work done DO NOT use retired	during mo	st of working		16b. Kir	nd of Busines	s/industry	
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yland	ould by Ments arked atic e	2	Lucien Heimbach 19a. Informant's Name/Relationship (7)	D.(14)		405 84-00	ng Address (Street	-	therine			Town State	Zin Cadal	
Ma	d2sh thand thand 7 is π trauπ		Patricia Heimbach	,, ,			idway Ave							
a,	s 1 an f Heal ttem 2 other		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of natory or other place		Date			cation - City o		9
e E	Page nent o ant: If ury or		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			view (Crematory	, Ind						yland
Бащтог	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylanc Department of Health and Mental Hygiene. Important: If the Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fune of Service Ucens	ee		22	Name and Address Bru	izdzii Faste	nski Fu ern Ave	neral	L Hom	ne, P.A	vland	21221
		_	23a. Part 1. Firter the disease, or comp shook, or heart failure. List only of	lications that caused	the death.								Approx	
F	Physician	ï	Immuniate Cause (Final divase or condition	, ISCHERNI		TROX	E						Onset a	and Death
-)	/Medical Examiner		refulting in death)	Due to (or as a		ence of):								
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2/20	certificate be executed ding physician and use as the burial-transit	edical		d										
Ď X	ding ding se a	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							2	23d. Date of c	lelivery	
ž Po Po	requires that the death certificaten signed by the attending planded be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnand Other (specify)					Month	Day	Year
л. Э	at the		9 ☐ Unknown Part II. Other significant conditions c		ut not resu	ıltina in the ı	underiving cause o	iven in Pa	rt I.	23e. Did 1	tobacco u	use contribute	to the cause	e of death?
gs,	signe ld be	d by	ATRIAL FLUTI	_				,		1 🗆		□ No 3 □		
	3 0 0	Completed	THA KIANOIRS	EN-Y DISEY	75 F					24a. Was		24b. Were	autopsy find	ings available of cause of
r	sician: The law certificate has b irector, page 2 a	Com	HYPERTENSION							perfo	ormed? 2X No	death	? es 2 □ No	
	yslcian: s certifica director,	Be (25. Was case referred to medical examiner?	Hospital: /34			Ott	nor:	ce of Death (C					
0	hys ald	6	1 ☐ Yes 2 ☑No 27. Manner of Death	Hospital: Hopaties 28a. Date of Injur		R/Outpatier 28b. Time o	I 3 L DOA	4 🗆 1	Nursing Home	5 🔲 Resi			ecify)	
0	Attending Ph or death. ector: After thi by the funeral	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	Woi	rk?]Yes 2	No					
DIVISION		Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of inju building, etc	ry - At hor (Specify)	me, farm, str	eet, factory, office		28f	. Location City or Tox		d Number or	Rural Route	Number,
	ura ille	Ce	29a. Certifier 1X Certifying Ph	ysician: To the best o	f mv know	rledge, deat	occurred at the ti	ime, date a	and place, and	d due to the	cause(s)	and manner	as stated.	
	the Hospital of thin 24 hours a the Funeral Dompletely filled in	edical		niner: On the basis of and manner sta	examinati									use(s)
	To the Hosp within 24 ho To the Fune completely f	Me	29b. Signature and title of certifier	- 1			29c. Licens				29d. Dat	e signed (Mo	nth, Day, Yea	r)
			Jan To	uln	M	۵		5.01	00		DCto	BER	23, 7	1011
			30. Name and address of person who		leath (Item	23a) (Type	Print)	1	940 Fac	tern Δ	venus	e. Baltin	ore. M	D, 21224
	Sta	ite	31. Date filed (Month, Day, Year)	32. Aegistra	r's Signati	ure	A 4		J . J E 43		3 31104	-, -		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33699 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Walter tteaden ไจ้ 2011 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death
Baltimore **Examiner** Gilchrist TOWSON 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign Country) If Under **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1**X** M 2 □ F Days 3 Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director must be notified Balto. Catonsville 1 Yes 2 No 10e. Street and Numbe 0 10g. Citizen of What Country? Mill USA ral", or items buld be filed within 72 hours after death vid Mental Hygiene.

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1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Funeral Director: After this certificate has Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 2 🔀 No HOSPICE မြ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 X Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Signature and title of certifie 29c. License number D 64395 OCTOBER 20, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA, MD 21044 6336 CEDAR LANE DAMELLE DOBERMAN, MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Medical 4a. Facility Name (# not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth ial Security Numbe **Funeral** Mgnth, Day, 1 ■ M 2 □ F Min. Director Usual Residence of Decedent 28a-f shov 10a. State 10b. 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral or items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Yes. Give Specify: "natural", Specify: HIS panio 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 54964 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 Is any injury or other tratonce. Method of Disposition cemetery, crematory or other place 20b. Place of Disposition (Name of Date Page 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) iverna permit. 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician rena Medical resulting in death) Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, bacing to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) signed by the attending physician d be detached for use as the burial Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available 24a. Was an page 2 autopsy performed prior to completion of cause of death? After this certificate has 2 🗌 No Yes 2 🛣 No 1 🗌 Yes Division of Vital 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Be examiner? Other: ၉ 1 Tes 2 **1** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) injury 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by determined City or Town, State) Medical 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date si ned (Month Day, Year 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 1337 PM HAROLD, EDWARD, JOHNSON 2011 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE UNIVERSITY OF MARYLAND MEDICAL SYSTEMS If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) Funeral Months Hours 0 1 / 3 0 / 1 9 3 7 1X M 2 - F 362-36-0201 MI Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b County 10d. Inside City Limits 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 🗌 Yes 2 😾 No MD Wicomico Hebron 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 7385 Firetower Road 21830 U.S.A. 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates. 55-76 1 Yes 2X No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Security Law Enforcement æ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ Edward Stanley Johnson Rosemond Arthur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fave Johnson (Wife) 7385 Firetower Rd., Hebron, MD 21830 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State cemetery, crematory or other place) Department of Important: If it any injury or o 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Ot Belle Haven, er (Specify) 10/22/11 Haven Cem. 22. Name and Address of Facility Thornton Funeral Home 24183 Chadbourne St., Parksley, VA 23421 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): Lukemia disease or condition Medical resulting in death) Examiner month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical IE EEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown been signed by the atte should be detached for Pregnant at time of death 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown RESPIRATORY FAILURG 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an NEUTROPENIA autopsy performed? 1 Yes 2 No 2 X No 25. Was case referred to medical or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 X No ဂ္ဂ 1 Manatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

Division of Vital 24 hours after death.
Funeral Director: After thi eted filled in by the funeral Hospital To the twithin 2.

29a. Certifier

29b. Signature and title of certifier

AGY MA, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore,

Box 68760

P.O.

Records,

State Registrar DHMH 17 Rev 7/2009 SOWMYA RAVI, 22 SOUTH GREENE STREET, BALTIMORE, MD, 21201

32, Registrar Signature

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1104115943

29d. Date signed (Month, Day, Year)

10,18,2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death OCTOBER. Physician/ Jones 1858 aven Medical 4a. Facility Name (if not institution, give street and number, Examiner 4c. County of Death CFT Greneral timore (In yrs. last birthday) 52 Yrs. Social Security Number If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Date of Birth **Funeral** 1 M 2 M (Month Day, **Director** 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at Funeral Director 1 Yes 2 No timore 0 10f. Zip Code 10g. Citizen of What Country? 21217 "natural", or items 23a USA Avenue 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic avant the state of the Completed by 1 Never Married 2 Married 2 No 1 Yes Specify Baltimore, Maryland 21215-003 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be ڡ Coute Number, City or Town, State, Zip Code) _Mailing Address (Street and Number or Rura Ka MONUTUA Himore Kobinson ourt WD 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State BaHimore 281 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat e of Funeral Service Licensee 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 2 No 2 🗆 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) director 2 1 No Other: 1 Yes Certificate: To 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner To the Sest of my knowledge 29b. Signature and title of certifier 10/19/11 30. Name and add of person of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hoper 404 am e Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and numbe Examiner 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age in yrs. last birthday) **Funeral** Hours Director 0V.1 narena 10d. Aside City Limits or 28a-f show 10b. County 10c. City, Town or Location 10a. State Examiner must be notified at Director Yes 2 No 10g. Citizen of What Country? 10e. Street and Numbe. 10f. Zip Code Funeral items 23a Was Deceden.
Armed Forces?
Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc 5 þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes, Give / Year or Dates Specify ortant: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Exar Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry Howa should be filed within 72.1 h and Mental Hygiene. 7 is marked other than "r fe. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) loua Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pri permit. Page 1 and 2 st.
Department of Health an
Important: If item 27 is any injury or are Lumpleis Jones an Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Scremation 3 Removal from State 10-29-4 Dopation 5 Other (Specify) of Funeral Service Licensee Nau disease, or complications that caused the death. Do not enter the mode of tying, such as cardiac or respiratory arrest ailure. List only one cause on each line. 23a. Flart 1. Enter the dis slock or hear ailu Immediate Cause final Approximate Interval Between Onset and Death Ph. i i n Acute myocandice disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) Pregnant at time of death the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown sephicemice should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy has perform To the Hospital or Attending Physician; The within 24 hours after death.
To the Funeral Director After this cartificate I completely filled in by the funeral director, pag Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ER/Outpatient 3 DOA 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 10-18-11 Name and address of person who completed cause of death (Item 23a) (Type, Print) Street aca 410 32. Registrar's Signature Date filed (Month, Day, Year, State 2 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33704 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 Jackson Z:52 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death of Maryland Medical Center Baltmore Universit N/ASocial Security Numbe If Under 1 Year If Under 24 Hrs 8. Date of Birth 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ★ M 2 □ F 83 Country) Director MD 28a-f show 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD N/ABaltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21201 USA 806 George St. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2x Married Yes Give Baltimore, Maryland 21215-0036 72 hours after 2 3 No 1 ☐ Yes 2 X No Specify: Specify: Black 3
Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry Various 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15, Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machine Repair Man Laundry Companies 12th N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mary Emma Jackson <u>William Edward Jackson</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra . Page 1 and 2 s' ment of Health a Barbara Harrison-Daughter NewCastle, DE 19720 Oakmont Dr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10/20/201 Halethorpe, MD 4 ☐ Other (Specify) Arbutus Memorial 22. Name and Address of Facility March F/H 1101 E. North 21. Signat re of Funeral Service Licensee Ave. Baltimore, MD 21202 part . Enter the disease, or complications that cau and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final Physician/ Abdunimi Aneurysm 2410 r condition Medical resulting in death) Due to (or as a consequence of): Examiner 24-Hemodynamic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): sician and burial-transit Exami that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death 1 Yes 2 No 9 Unknown as been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? Completed by Division of Vital Records, 1 \square Yes 2 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? the funeral director, page performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗌 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 2 Accident Investigation 1 Yes 2 No after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 10/11/11 101501 and address of person who completed cause of death (Item 23a) (Type, Print) 22 5. Greene Street Raltimore Date filed (Month, Day, Year) 32. Registrar's Signature State 2 4 2011 Registrar

DHMH 17 Rev 7/2009

1-07963 Eugene Kantener		nd / Department o	f Health and Mental I		ble. 2011 3370
	1- For State Registrar	Certificate o	f Death	Reg.	No.
Physician/ Medical Examiner				2. Date of Death Month Da October 23,	
	4a. Facility Name (if not institution, give street and nur Civista Medical Center	nber)	4b. City, Town, or Location of Dea LaPlata	th	4c. County of Death Charles
Funeral		7. Age (In yrs. last birthday)	If Under 1 Year If Under 24I-	rs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Director		40 Yrs	Months Days Hours M	in. 06/12/	Foreign
	Usual Residence of Decedent	40	<u>" </u>	1007127	13/1
' any	10a. State 10b. County	10c. City, Town or Loca	tion		10d. Inside City Limits
Aaryland 28a-f show 1 at once. ⊖ctor	PA Luzerne	Hazle Tow			1 Yes 2 X No
death with the Maryland or items 23a or 28a-f sho must be notified at once.	10e. Street and Number		10f. Zip Code		Citizen of What Country?
th the 23a o notifi	841 Old Street 11. Marital Status 12. Was Dece	edent Ever in U.S. 13, W	18202 as Decedent of Hispanic Origin? (J.S.A. 14. Race - American Indian, Black,
er death with t , or items 23. r must be not Funeral	1 Never Married 2 Married Armed Fo	rces? If \	res, specify Cuban, Mexican, Puer		White, etc.
E', fe	3 Widowed 4 Divorced If Yes, Give Year or Dates:	2 X No	Yes 2 No specify:		_{Specify:} White
atura atura	15. Decedent's Education (Specify only highest grade	e completed) 16a Deceder	nt's Usual Occupation (Give kind on nost of working life, DO NOT use n		6b. Kind of Business/Industry
5-0036 ed within 72 hours after than "natural" the Medical Examine Completed by	Elementary/Secondary (0-12) College (1-	4 or 5+)	•	, I	Dog Food Manufacture
within yiene.	1 2	Labo		ne (First, Middle, Maid	
11215-0036 Id be filed within 72 hours al Acatal Hygiene. arrised other than "natural event, the Medical Examin O Be Completed by	Eugene Kantner, Sr.			et Irene	· ·
212 tould be d Ment d Ment if ever	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Number o	r Rural Route Number	r, City or Town, State, Zip Code)
nore, MD 2 gges 1 and 2 shoul nt of Health and n t: Uitem 27 is n other traumatic	Cynthia Kantner (Wife		old Street, Ha		
re, s 1 an f Heal If iten er tra	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal fro		sition (Name of cemetery, ther place)	Date 2	0c. Location - City or Town, State
Page nent o	4 Donation Other Specify:	Mountair			McAdoo, PA
Balt Dermit. Depart Import	21. Signature of Jul., al Service Licensee	22.1	Name and Address of Facility Bo	oyle Fune	eral Home
	23a. Part I. Ener the disease, or complications that ca		00 S.Wyoming Sthe mode of dving, such as cardiac		
Physician IV and IV	failure. List only one cause on each line.		, 0,		Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Multiple Inju	consequence of):			
	Sequentially list conditions, b				
in a second	cause. Enter Underlying Cause	consequence of):			
ted Insit Examiner		consequence of):			
a 2 2 1 -	d.				
760, icate be exe g physician s the burial -	UNPENDED AMENDED				22d Data of daliyany
1876 tiffcat ing ph as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, o	utcome of pregnancy rth , ₂ Fe	etal death 3 Ectopic preg	nancy	23d. Date of delivery Month Day Year
Box 68760, s death certificate be the attending physic of for use as the bur hysician/Mec	4 Pregna		ther (Specify)		
D. Box 68760, the death certificate be exemple, by the attending physician anothed for use as the burial Physician/Medica			underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
P.O. res that the signed by be detach	•	----		1 Yes	2 ✔ No 3 Probably 4 Unknown
ords, w require us been si should b				24a. Was an	24b. Were autopsy findings available
Division of Vital Records, Ital or Attending Physician: The law requires is after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be artification: To Be Completed				autopsy performe	
Vital Rec	25. Was case referred to medical		26.Place of Death (Chec	1 Yes 2	No 1 Yes 2 No
f Vital Physician: ar this certiral director To Be	evaminer?	patient 2 ER/Outpatien			sidence 6 Other:
ling Ph After ti funeral	27. Manner of Death 28a. Date of (Month.	of Injury 28b. Time of Day Year)		28d. Describe how Driver auto aut	
Division of spital or Attending hours after death. hours after death. filled in by the fune. Certification:	1 Natural 5 Pending Oct 23, 2 2 Accident Investigation	0136 hrs	1 Yes 2 ✓ No		
ivision I or Atteno after death Director: d in by the	3 Suicide 6 Could not be 28e. Place		et, factory, office building, etc.	28f. Location (Stre or Town, State S/B Route 301, L	et and Number or Rural Route Number, City
Division Bivostal or Attend 24 hours after death Paneral Director: reby filled in by the	4 Homicide	Major Road / Highway			
Di To the Hospital within 24 hours a To the Kunerall completely filled	one) 2 Medical Examiner: On the basis o	f examination and/or investiga	rred at the time, date and place, a ition, in my opinion, death occurre	nd due to the cause(s d at the time, date and	d place, and due to the cause(s)
To rom	and manner st 29b. Signature and title of certifier	ated.	29c, License number		9d. Date signed (Month, Day, Year)
	0_~()_		O.C.M.E.		October 23, 2011
	30. Name and address of person who completed cause				
101			W. Baltimore Street, Balt	imore, MD 2122	3
State Registrar	DOT A A COLL	gistrar's Signature			

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 1¹1, 201¹1 11:48 AMM Leon Kreitman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northwest Hospital Randallstown Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Hours Days Min (Month, Day, Year) 400-40-3100 79 Director 1 X M 2 □ F Feb 21, 1932 Kentucky Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location 72 hours after death with the Maryland Director 1X Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1700 Woodholme Avenue 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 51-54 If Ves, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Completed 3 Widowed 4 X Divorced Specify: white Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene.
7 is marked other than "n College (1-4 or 5+) 5+ Elementary/Secondary (0-12) healthcare school psychologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Abraham Kreitman Minnie Covitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh tment of Health a tant: If item 27 is 913 Rappaix Court Towson, MD Daniel Kreitman/son permit, Page 1 and 2 Department of Healt Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 21. Signalune J Funeral Stryic 3tareendAddateonfyciiiBoard 655 W. Baltimore Street Baltimore, MD 21201 boter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death eart failure. List only one cause on each line Immediate Cause (Final disease or condition Phyllician. XIGTION to (or in a consequence of) VXICTION Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ ō in the past 12 months? Month Day Year Pregnant at time of death signed by the at d be detached for Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ I or Attending Physician: The law requires after death. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform 24 hours after deam, s Funeral Director; After this certificate hetely filled in by the funeral director, pag 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Certificate: ☐ Natural 5 Pending unknowNM ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) \7.60 Wood holm & Auc 4 Homicide determined building, etc ASSISTED Kesuille the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred of the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hound To the Funer completely fi 29a, Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

State Registrar Date filed (Mo

23a) (Type, Print)

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	•	for State Registrar		· · · · · · · · · · · · · · · · · · ·		tificate of D				leg. No.	011	33707
Physicia	m/	1. Decedent's Name (First, Middle,							Date of Deat Month	th Day	Year	3. Time of Death
Medic	cal	Thomas S.				[] all =		(D. II.	Oct 21	, 201	1	23:27 M
Examin	ier	4a. Facility Name (if not institution, of Southern Marylan)		er)		4b. City, Town, or Clinton		of Death			County of Dea Prince (
Funeral				Age (In yrs. last birt	hday)	If Under 1 Year Months Days	If Under Hours	24 Hrs.	8. Date of Birth (Month, Day,		9. Bir	rthplace (State or Foreign
Director		577 24 7955 Usual Residence of Decedent	1 🗙 M 2 □ F	90	Yrs.	WORKI'S Days	llouis	IVIIII.	June 26,			shington DC
and show l at	or	10a. State 10b. County		10c. City, Town	n or Loc	cation	-					10d. Inside City Limits
Maryla 28a-f	irect	Maryland Prince	George's	For	resty	ville						1 ☐ Yes 2XX No
th the	Funeral Director	10e. Street and Number				10f. Zip Code			:	10g. Citize	en of What Co	ountry?
ath wil	nner	7015 Nimitz Drive	12. Was Decede	nt Ever in LLS	13 V	20747 Vas Decedent of His		ain? (Spe	cify Yes or No-	_	ed State 4. Race - Ame	
er dea or ite miner	by F	1 ☐ Never Married 2 ☐ Marrie	Armed Force 1 Yes 2	s?	If	Yes, specify Cubar	n, Mexicar	n, Puerto	Rican, etc.)		Black, Whit	
urs aff :ural", al Exa		3 Widowed 4 Divorced	If Yes, Give Year or Date			Yes 2 No				Sp	Specify: W	hite
72 ho n "nai fledica	Completed	15. Decedent (Specify only highes	t grade completed)		(Give k	ent's Usual Occupa kind of work done du O NOT use retired)		t of worki	ng	16b. Kind	d of Business	/Industry
within giene. er tha		Elementary/Secondary (0-12) 12	College (1-4			efighter					Fire	Dept
filed tal Hyger of other event.	To Be	17. Father's Name (First, Middle, La	st)				18. Moth	er's Name	e (First, Middle, M	∕laiden Su	urname)	•
should be filed within 72 hours after death with the Maryland nand Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified a	٦	Aloysius	Llo						Sanford_			
2 sho Ith and 27 is i		19a. Informant's Name/Relationshi Esther — Ester Lloyd (Wif		19b		g Address (Street a					own, State, ∠	ip Code)
1 and of Heal item 2		20a. Method of Disposition			f Dispos	Nimitz Dr sition (Name of natory or other place			e, MU 20/2		ation - City o	r Town, State
Page nent o ant: If ury or		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		ate	ecti	on Cemeters	,	10/26	/2011	Clint	ton. Md	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lic	censee	WORLL	22	. Name and Address	s of Facilit	Lee 1	Funeral Ho	ome,In	nc 6633	Old Alexandria
## ## ## ## ## ## ## ## ## ## ## ## ##		23a. Ran 1. Enter the disease, or o	omplications that cau	ised the death. Do r		-CITY MINU	,	ши,	1.11. TOLY			Approximate
Physician/		shock, or heart failure. List on Immediate Cause (Final	lly one cause on each	ine.	- 2	7 001	100	101	180 la	-12	8000	Interval Between Onset and Death
Medical		disease or condition resulting in death)	a. Due to (or	as a consequence	of):	2	acce	101	3000	11)	/scar	- williamony
Examiner	7	Sequentially list conditions,	b. Isch	ence	1	Owe	V_	12	se	- 4	Inthrow /	
ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	Cid					Un the and			
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atteno atteno I for us	ician	.23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 🔲 Live Bir	th 2 Fetal death nt at time of death		Ectopic pregnancy Other (specify)	¥			23	3d. Date of de Month	Day Year
requires that the des been signed by the s should be detached	hys	9 Unknown	9 🗌 Unknov									
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require	eted	1.2000										Probably 4 Unknown
e law i e has k ige 2 s	Completed by								24a. Was a autop: perfor	sy med?	prior to death?	completion of cause of
an: Th tificate tor, pa	Be Co	25. Was case referred to medical				26. Pla	ice of Dea	ith (Check	1 Yes	2 No	1	es 2 🗆 No
Physician: The law this certificate has ral director, page 2 a	To E	examiner? 1 Yes 2 10	Hospital:	patient 2 ER/Ou	utpatien	t 3 DOA Othe	r: 4 🗆 N	ursing Ho	me 5 Reside	ence 6	Other (Spe	cify)
Jing P. J. After ti	ate:	27. Manner of Death 1 Natural 5 □ Pending			Time of njury	28c. Injury work? M 1 1			28d. Describe ho	ow injury o	occurred	
I or Attendi after death. Director: A d in by the fu	Certificate:	2 Accident Investiga 3 Suicide 6 Could not determine	ot be 28e. Place of	Injury - At home, fa	rm, stre		162 2	NO			Number or Ri	ural Route Number,
tal or rs afte al Dire		4 E Hornicide determin	building	, etc. (Specify)					City or Towi	n, State)		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate has been signed by the attending physici To the Lunaral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but	Medical	(Check 2 Medical Ex		of examination and/o	or invest	igation, in my opinio	n, death o	ccurred at	the time, date ar	nd place, a	and due to the	cause(s) and manner stated.
o the vithin 2 the comple	ž	only one) 6 Certifying 29b. Signature and title of certifier	Practitioner: I	the best of my know	wledge,	death occurred at the 29c. License		ite and pla			and manner signed (Mon	
		DIA/	194A			50	45	4	Ł	cle	o Res	122/2011
ntV		30. Name and address of person w	ho completed cause	of death (Item 23a) (Type, P	rint)	7 2		20.	7) 1/14	170732
Sta	te	31. Date filed (Month, Day, Year)	32. reg	istrar's Signature	7 J	Title	د ۲))	at /	ca	~ / · · ·	12/33
Registra		CT 24	7111 /3.		Asi.	ON No. 1						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9:00 p October 20 2011 ERNESTINE ALICE LARKINS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner GENESIS HOMEWOOD CENTER BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 X F OCT. 12 1921 Director 90 VIRGINIA 224-18-3853 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County items 23a or 28a-f show must be notified at XXYes 2 □ No Director MARYLAND N/ABALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must. once. 21229 29 N. MORLEY STREET Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXVo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify Specify: BLACK þ 3XXWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) BEAUTICIAN 12yrs 2yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOSEPH ROBINSON ၉ MARY HOWARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Morley Ave., Baltimore, Md., 21229 29 N. Angela Larkins/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 10-28-2011 OWINGS MILLS, MARYLAND 5 ☐ Other (Specify 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME
1206 W NORTH AVENUE 21. Signatur Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician d /Medical Due to (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to for all a consequ Examiner pital or Attending Physician: The law requires that the death certificate be executed burs after death. eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Atter this certificate has been signed by funeral director, page 2 should be detac 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Untural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print) Bours 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Gladys Louise Melka 216 AM 2011 Medical 10 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUAGE HOSPITAL Baltimore Rosedal 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Feb. 15, 1924 113 14 9005 Director 87 New York Usual Residence of Decedent 28a-f show 10b. County Director 10a. State 10c. City, Town or Location death with the Maryland be notified at 10d. Inside City Limits Maryland Baltimore Middle River 1 Yes 2 X No ō 10e. Street and Numbe 10g. Citizen of What Country? 23a Funeral 6921 Birdwood Avenue permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23; any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, 21220 USA . Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Irwin Drumm Hazel Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa A. Cohen (Daughter) 522 Cole Lane Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gardens 10/24/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdziński Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between nock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physici_n/ disease or condition resulting in death) Sepsis Medical Due to or as a consequence of) Examiner yocardia In farction Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed multisystem Failure organ ending physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 the attending 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ ō in the past 12 months?

1 Yes 2 No Month Year detached 9 Unknown 9 Unknown this certificate has been signed by ral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Be (25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After 1 Natural (Month, Day, Year) 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) pateli up -21-2011 RESOOOO 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 4000 FRANKLIN Square DR Patel Vaideep Balto 31. Date filed (Month, Day, Year) **OCT 24 2011** State 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

1148 PM Charles Milligan 10/17/2011

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any hjury or other traumatic event, it a Medical Examinating must be notified at once. Funeral 1XXYes 2 □ No If Yes, Give Year or Dates: unk 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ 3 Widowed WDivorced Completed PHENE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Landscaper unk unk unk 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type, Print)
Steve Stengler-Friend
Baltimore County Police Dept 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 NOther (Specify) in state re of Funeral Service Liebr 21. Signatu Director Baltimore, MD 21201 2a. Part1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Immediate Caus Final disease or condition resulting in death) Cardiovascular Disease Physician a Arteniosclenatic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physicien: The law requires thet the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy jo 5 Cther (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ Completed 24a. Was an r this certificete has autopsy performed 25. Was case referred to medical examiner?

1 X Yes 2 No Be 26. Place of Death Check only one Hospital: 1 | Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No death. М efter death the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 - Homicide within 24 hours a
To the Funeral I
completely filled Hospital pelli 29a. Certifier (Check only one) To the I 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD. CTLu PMILITELLO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #9,11,12,16a&B&19a&b Per ANA BD C920 10/24/2011 JH

State of Maryland / Department of Health and Mental Hygiene

amend #1 Per FH G925 3/22/2012 JH

Certificate of Death For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Milligan Mulligan **Physician** Month Year Charles S. October 0 17, 2011 11:48 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 10715 Liberty Road Baltimore Randallstown If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) Unik New Jersey 5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb 6, 1943 1⊠M 2□F 68 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Directo Baltimore Randallstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 10715 Liberty Road 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Specify: white 16b. Kind of Business/Industry Flowers Farm unk 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk 9032 Old Court RD: Windsor Mill, Md 21244 20c. Location - City or Town, State State Anatomy Board 655 W. Baltimore Street Approximate Interval Between Onset and Death 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 X-No Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) October 18,2611 Trimble Hill 6 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

OCT 2 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1953 moreland Medical 10 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis Anne Arundel Medical Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) **Director** 213-22-2121 1 XM 2 □ F Maryland Nov 3, 1924 Usual Residence of Decede or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rector 1 Yes 2 X No Anne Arundel Lothian Ö 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral P.O. Box 22 20711 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: item 27 is marked other than "natural", other traumatic event, the Medical Exar Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) foreman 11 O Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Herman Moreland Sr Lila Mae Crandall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Phipps/daughter P.O. Box 241 Lothian, MD 20711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o þ ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Konald State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 m 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or heart failure. List only one cause on each line Immediate Sause (Final Physician/ LORONA RY disease or condition years Medical resulting in death) Examiner Hyper lipidemia Sequentially list conditions, if any leading control of cause. Enter Underlying Cause (Disease or injury that initiated experts) Examine attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death ed by the a detached t g Unknown 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2No 3 Probably 4 Unknown Completed 1 Tes 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed? death? certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 잍 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of

Registrar

St #201.

3/69 Braverten

sewater, MA 21037

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier

33712

					Certificate of	Death		Reg. No.			
			1. Decedent's Name (First, Middle, Las				2. Date of De Month		3. Time of Death		
	Physic		JUNITA	Muole			OCT	12 20	/ear		
١.	/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or L	ocation of Deat	4c. County of			
1	LXamii	ici	VILLA ROSA NU	RSING HOME		MITCHELI	LVILLE	PRINCE	GEORGE'S		
П	Funeral		5. Social Security Number 6. Se	7. Age (In vrs. last I	birthday) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bir (Month, Da	th s	Birthplace (State or Foreign Country)		
, and	Director		262-48-7570	□M 21XF 87	Yrs. Months Days	Hours Will.	OCT.		GEORGIA		
	ъ		Usual Residence of Decedent								
	how		10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits		
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	23e	a	6545 HILMAR DRIV	/E #303	20747	7		USA			
	dea e	Funeral Director	11. Marital Status	12. Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Sp	ecify Yes or No	14. Race - Black.	- American Indian, White, etc.		
0	or ite	E	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🕅 No If Yes, Give	1 □ Yes 21 No		,,	Specify:	BLACK		
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21215-0020	within 72 hours after death with the Maryland ene. then "neturat", or items 23e or 28e-f show to Modical Examiner must be rediffed at	Completed	15. Decedent's Edi (Specify only highest grad		Sa. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	ipation a during most of work	ring	16b. Kind of Busi	ness/Industry		
21	should be filed within and Mental Hygiene. s markad other then " numatic event, the Mar	ď	Elementary/Secondary (0-12)	College (1-4or 5+)							
	wgier ort	ပ္ပိ	6th		FACTORY WOR			PRIVAT			
P	tal H	Be	17. Father's Name (First, Middle, Last)				•	, Maiden Surname)			
<u>Y</u> a	should ind Men i marka umatic	ို	UNKNOWN			UNKNOWN					
Maryland	2 sho and is ma raume		19a. Informant's Name/Relationship (7)	ype, Print)	9b. Mailing Address (Stree	et and Number or Rui	al Route Numb	er, City or Town, Si	tate, Zip Code)		
	s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. The markad other then "neturat", or items 23e or 28e-f show then 27 is markad other then "neturat", or items 25e or 28e-f show other traumatic event, it is "Modical Examiner must be notified at		SARAH WILLIAMS/DO	T	6545 HILMAR of Disposition (Name of	DRIVE #30	3 DISTE	RICT HGTS	, MARYLAND		
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Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Hearly or other tra eny Injury or other tra once.		21. Signature of Funeral Service Licens	see 0 0 .	22. Name and Add	ress of Facility ${\sf J}$.	B. JENE	INS FUNE	RAL HOME, INC.		
Ω	8 9 E 8		1 Washmers A	(pomolius	7474 LANI	OOVER RD.	HYATTSV	ILLE, MARY	YLAND 20785		
		-	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. D	o not enter the mode of dy	ring, such as cardiac	or respiratory a	arrest,	Approximate Interval Between		
	Physician		shock, or heart failure. Listonly of	ne cause on each line.	\wedge				Onset and Death		
1	/Medical		Immediate Cause (Final	D 1 1+-		1	Illas		Mark.		
	Examiner		disease or condition resulting in death)	a. Due to (or ac	a consequence of):		Think		1.0		
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68760,	e be /sicia e bu	cal	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a	a consequence of):						
89	ifficet g phy as th	ledi	resulting in death) Last						i		
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. Bo	death death	icla	Part II. Other significent conditions co	ntributing to death but not resulting	in the underlying cause o	iven in Part I	23b. Did	tobecco use cont	ribute to the ceuse of death?		
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of Vital Records,	The law requires that the death certificete be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriel-transit						24a. Wa	an autopsy	24b. Were autopsy findings available prior to		
8	v require been sig should b	lete					pen	ormed?	completion of cause of death?		
Re	has ge 2	Completed					10	Yes 20 No	1 □ Yes 2 □ No		
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⋚	sicial certi irecto	o Be	evaminer?	Hospital: 1 ☐ Inpatient 2 ☐ ER/6	Outpatient 3 DOA			idence 6 □Other	(Specify)		
of	Physician: r this certific aral director,	. To	27. Manner of Death		o. Time of 28c. Inj	ury at		how injury occurre			
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Division	Attending or death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home,	farm, street, factory, office	9			r or Rural Route Number,		
⋛	or A after Direction by	erti	4 ☐ Homicide determined	building, etc. (Specify)	,,,,		City or To	iwn, State)			
	To the Hospitel or Attending Physician: The Is within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	0	29a. Certifier Certifying Phy	sician: To the best of my knowled	ge, death occurred at the	time, date and place	and due to the	cause(s) and man	ner as stated.		
	24 h Fun etely	edical	(Check only 2 Medical Exeminate)	iner: On the basis of examination and manner stated.	and/or investigation, in my	opinion, death occu	red at the time	, date and place, ar	nd due to the cause(s)		
	o the o the omple	Me	29b. Signature and title of ceptifier		29c. Licer	nse number		29d. Date signed	(Month, Day, Year)		
	⊢ 3 F ŏ		I	No un	Di.	2)(1		10/19/	10		
	1/8/		30 Name and odds of	empleted eques of death //ter- 22-		1261		(1, 1)			
	1 7		30. Name and address of person who c	ompleted cause of death (Item 23a	11 1	1-0 1	Anton	m 2	206		
			31. Date filed (Month Pay Year)	32. Aegistrar's Signatur	0000	1	11	٧)			
8.	Sta	ne	UCT 2 4 20	111 Aura A	backer						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year 927 Helen Mayer AM A Medical 10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN Squase Hospital Center os edal + Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F Days Hours 219-10-3645 Min. September 30, 1926 Director Maryland Usual Residence of Decedent show 10b. County 10a, State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Baltimore 1 🗆 Yes 2 🗐 No Maryland Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 8 Farwell Court 21236 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 'natural", or \$ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. Yes 2 XNo 21215-0036 1 Yes 2 No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced Specify: White Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) n and Mental Hygien 8 vears Housewife Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Henry Joseph Welsh Anna Marie Baron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 27 Justine Mayer Chemelli daughter 8 Farwell Court, Nottingham, Maryland permit, Page 1 and 2 Department of Health Important: If item 2: any injury or other toone. Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 1 Burial 2 XCremation 3 Removal from State Bavview Crematory Baltimore, Maryland 4 Donation 5 Other (Specify) 24, 2011 21. Signature of Fune al Service Licensee Conneily Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line complications that caused the death on not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Bilateral Cerebral disease or condition resulting in death) Acute infacction Day Medical Due to (or as a consequence of): Examiner Value AOSTIC eals Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence or) Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Selzure disorders 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 1 Tes 2 🔄 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗌 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, within 24 hours after death.

To the Funeral Director: After this certificate

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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (0 30. Name and addless of person whe ompleted cause of death (ten 23a) (Type, Print) Kamlun AUYEUNG FRANKLIN Sauate DR Balto md ZIZ37 4000 31. Date filed (Month, Day, Jear, State Registrar

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a. Certifier

only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:40 A M Susan Joan Masing Medical 18. 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Southern Maryland Hospital Prince George's Clinton 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 5 Social Security Numbe 570-29-1922 **Funeral** Days Hours Min. (Month, Day, Year) Director 1 □ M 2 XX 53 Yrs CA Feb 25, 1958 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at ems 23a or 28a-f sh Director 1 Yes 2 XNo Maryland Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4326 Hartford Hills Drive 20746 United States ir than "natural", or items the Medical Examiner mu and 2 should be filed within 72 hours after death Was Deceue...
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1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: "natural", Specify: 3 ♥ Widowed 4 □ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Il Hygiene. Disabled N/A event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic evenoce. ည Roy Harold Bateman Althea Joan Bauman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 173 D Berkeley Farms Road, Summerville, SC 29483 Shannon Masing (Daughter) altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD Oct 21, Lee Crematory Signa ure of Funeral Service Licer 22. Name and Address of Facility Lee Funeral Home, Inc 663301d Alexandria Ferry Road. MD 20735 Clinton. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequent of): burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Medical Box 68760 the as IF FEMALE: nse Physician/ 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy the Hospital or Attending Physician: The law requires that the death ò Month Day Year Pregnant at time of death ed by the a 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has perform Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Tyes ျပ 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Time of 28b. 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Director: / 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 2011 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) filed (Month, Day, Year Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) 17.00 Month **Physician** HILIP 2011 atobe CWARCEF /Medical 4c. County of Death 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Mooths | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Days Hours Aug 20, 1919 Director 579-07-4454 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show 1 Yes 2 No ä iral", or items 23a or 28a-f si Examiner must be notified Director MD Baltimore 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 21218 USA 300 Old York Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 11. Marital Status Black, White, etc. 2 No 1 ☐ Never Married 2 ☐ Married ☐ Yes į. 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify white ģ 3 Widowed 4 Divorced Completed unk 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) Injury or other traumatic event, 17. Father's Name (First, Middle, Last) unk Maryland Be ould be 2 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health a Important: If item 27 is any Injury or ~1. Johns Hopkins Bayview Med Ctr 4940 Eastern Avenue Baltimore, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 X Other (Specify) in state ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Licensee Ronald S Wade Director 2222 Baltimore, MD Pat 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BULLEY HOUR **Physician** disease or condition resulting in death) /Medical Examiner NEUHONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Box 68760, Physician/Medical 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Dav Year in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 Nonknown 1 TYes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 🗌 No 1 TYes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural Injury or Attending 1 Yes 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of sortifier OCTOBER 14. 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 MI) HCCORSO. TNTHON

DHMH 17 Rev 1/2001 11595

State Registrar 31. Date filed (Month, Day, Year)

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day **07** OCT JOHNNIE PORTER JR 2011 A^{M} 2:35 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **BETHESDA** WRNMMC MONTGOMERY Social Security Numbe . Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months 250-46-0449 Days 1**X**□ M 2 □ F Hours 2-29-1935 75 **Director** South Carolina Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD PG Springdale Yes 2 No 10f. Zip Code 20774 Street and Numbe 10g. Citizen of What Country? 9704 Canary Ct. USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No 1956—

If Yes, Give 1993 Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify Black 3 Divorced 1982 Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Supply Management US Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jessie Johnnie Porter Sr. Porter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9603 Varus Pl. Upper Marlboro, MD 20772 Valarie Porter/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat'l Cem. 12-14-2011 4 Donation 5 Other (Specify) Arlington, VA 21. Signature of Funeral Service Licenses 22. Name and Address of FacilitiRonald Taylor, II FH 10583 Middleport Ln. White Plains, MD 20695 Kond 23a. Part 1. Enter the disease, or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PULMONARY HEMORRHAGE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner MULTIPLE MYELOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence or) attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical þ 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2X N certificate 1 ☐ Yes 2 💢 No of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 ▼ Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 X-Natural To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28b. Time of Certificate: 28c. Injury at 5 Pending work? Division 2 Accident
3 Suicide
4 Homicide Investigation 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) A106299 CA 30. Name and addr es of person who completed cause of death (Item 22a) (Type, Print) JONATHAN A BOLANOS MC USN LI WRNMMC, BETHESDA, MD 20889 5600 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

11-07476 Unk Unk Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physicia	ın/	Decedent's Name		,						Date of Dea Month	Day	Year	3.	Time of Death 0810 hrs
Medical Examir	ıer	Debora 4a. Facility Name (if	h McCart		er)		4h City To	vn or Loca	ation of Death	October 5		c. County of	Death	00101115
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Aaryland 28a-f show 1 at once.	Director	10e. Street and Num				Turk	10f. Zip C	ode		1	0g. Cit	izen of What	t Country	n
MOVE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23n or 28n-f sho r other traumatic event, the Medical Examiner must be notified at once.	ä	2505Park	Trail	Road			2	1234				USA		
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212 Auld be Ments mark		George I 19a. Informant's Nar	ne/Relationship (Type, Print)		19b. Mailing	Address	(Street and		Rural Route Nur		City or Town,	State, Z	ip Code)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin	_	John Scl		sin						timore,		2122		
of Heal		20a. Method of Disp		Removal from		Place of Dispos crematory or ot		of cemeter	ry,	Date	20c.	Location - C	ity or To	wn, State
Baltimore, permit. Pages 1 ar Department of He Important: Uite		4 Donation 5	X Other Specif	y in stat								- 1, 10		
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Physician	1	2 a. Part I. Enter the			sed the death.	Do not enter t	ne mode of	dying, such			est, sh	ock, or heart		Approximate Interval
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that the detached	형	Part II. Other signifi	icant conditions	contributing to de	eath but not re	esulting in the u	anderlying c	ause given	in Part I.					e cause of death?
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Division pital or Attend ours after death teral Director:	Certification:	3 Suicide	6 X Could no determine	t be		ome, farm, stree			rig, etc.	or Town,	State) 2	2505 Pa	ark I	rail Rd.
7 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		4 Homicide 29a. Certifier (Check only 1	Certifying Physic	clan: To the best o					nd place, and	Parkvi: due to the cau			s stated.	
To the Hos within 24 h To the Fun Completely	edical	one) 2 🗸 1	Medical Examine	er:On the basis of e and manner state		nd/or investiga	tion, in my o	pinion, dea	ath occurred a	at the time, date				
	ž	29b. Signature and t	itle of certifier	- , 5				icense nur D.C.M.E			1 .	Date signed tober 6, 2		, Day, Year)
		20 North 12	an of a		of docth (III	220)		J.∪.IVI.⊏						
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	ate	31. Date filed (Month		1.0	strar's Signatu	park								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 19-2011 7:00 AM 10-Medical 4a. Facility Name (if not institution, give street and number) opunty of Death **Examiner** larrio aret Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Director 7-15-1959 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ş 1 Never Married 2 N Married 1 ☐ Yes 2 ☑ No Specify If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 formant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Important: If item 27 is any injury or other trat once. 20b. Place of Disposition (Name of centerry, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral/Service Licensee Name and Address of Facility Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Concep year disease or condition resulting in death) Medical Examiner Failure Sequentially list conditions, Examiner if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury burial-tran and that initiated events resulting in death) Last Medical Certificate: To Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 ☐ Yes 2 ¥ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 N 2 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Natural 5 \square Pending Accident 1 Yes 2 🗆 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Dired 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Set Hymney in Figure 1. The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie nuemo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 5. Hanover 3001 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year nn WOE 2011 oma 16 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under 24 Hrs Hours Min. Birthelace (State or Foreign Country) Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months Days Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Cumberlan 1 XYes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No LYes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Year or Dates: WWTI 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) nomas 1 hac 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 □ Burial 2 □ Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) of Funeral Sarvio State Anatomy Board 655 w. Baltimore Street 21201 Baltimore, MD Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate us (Final disease or contilion resulting in death) O MONTH Due to (or as a consequence of): Sequentially list conditions, if any, leading to min-order cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 1 ☐Yes 2 ☐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing He 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Natural 2 ☐ Accident 5 Pending

Physician /Medical Examiner Physician: The law requires that the death certificate be executed

Department of Health a Important: If item 27 is any Injury or other tra once.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

23a or

or items,

"natural"

72 hours after

should be filed within of Health and Mental Hygiene. fitem 27 is marked other than

Pages 1 and 2

Baltimore, Maryland 21215-0036

Director

Funeral

<u></u>

Completed

Be

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Examiner

Completed by Physician/Medical

Be (

traumatic event, the Medical Examinar must be notified at

attending physician and for use as the burial-trar been signed by the atte should be detached for page 2 s funeral director After this

Division of Vital Records, P.O. Box 68760,

Hospital or Attending

after death. Director: Af

completely filled in by within 24 hours a

To the Funeral D

9 LI Unknown				
other significant conditions	contributing to death but not res	ulting in the underlying cause give	en in Part I.	236
Cthosic of	Brevence	PULMONAR	12848	248
				1 🗆
. Was case referred to medical			26. Place of Death (0	Checi
examiner?	I I I mamiliants	0.11		

	23e. Did tobacco use	e contribute to the cause of death?
	1 □ Yes 2 □	No 3 Probably 4 Unknown
_	24a. Was an autopsy performed? 1 □Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
th (C	Check only one)	
ome	e 5 Residence 6	☐ Other (Specify)
280	d. Describe how injury	occurred
0.04		

Certification: To	1 ☐ Yes 27. Manner of 1 ☐ Natura 2 ☐ Accide 3 ☐ Suicid 4 ☐ Homic	al ent
dical	29a. Certifier (Check or one)	nly
Ž	29b. Signature	9 8

investigation 6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 No

Road Ste 450 Cumberland, MD 21502

Location (Street and Number or Rural Route Number, City or Town, State)

(Check only

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier,

201

29d. Date signed (Month, Day, Year)

State Registrar

Robert A. Welk 31. Date filed (Month, Day, Year)

12502 Willowbrook Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State of M	aryland / D		nt of H	lealth		al Hygi		gible.	33720
	Physicia Media		Decedent's Name (First, Middle, Lass Joyce Lillian Section	llak					Mo	te of Death onth ctober		Year 2011	3. Time of Death 10:45 AM
and the second	Examir		4a. Facility Name (if not institution, give 712 Sue Grove Rd.			4b. Cit	y, Town, or Esse		of Death		4c. County	of Death	
	Funeral		5. Social Security Number 6. Social Security Number 8. Social Security	9x 7. Ag	e (In yrs. last birth	lay) If Und Month	er 1 Year	If Under Hours		te of Birth onth, Day, \			place (State or Foreign
	Director		Usual Residence of Decedent	□м 2 🛣 7					Dec	.22,	1937		yland
	/anylane/ 8a-f sh tified a	Director	10a. State	ore	10c. City, Town	Essex						1	0d. Inside City Limits 1 ☐ Yes 2 No
	with the N 23a or 2 ust be no		10e. Street and Number 712 Sue Grove Rd.			10f. 2	ip Code 212	21		10	ng. Citizen of		ntry?
9800	2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	ted by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.	_	If Yes, sp		n, Mexicar	gin? (Specify Yes n, Puerto Rican, e		Bla	ce - Americ ck, White, c	etc.
Maryland 21215-0036	iin 72 hou re. han "nat e Medica	Completed	15. Decedent's E. (Specify only highest grant Elementary/Secondary (0-12)	ducation ide completed) College (1-4 or 5		ecedent's Us Give kind of w e. DO NOT u	ork done d se retired)	luring mosi	t of working	1	6b. Kind of B		dustry
d 21	filed within al Hygiene.	Be C	12 17. Father's Name (First, Middle, Last)		·	Hou	sewif		er's Name (First,	Middle Ma	Own H		
ylan	should be file n and Mental F 7 is marked o raumatic eve	욘	Chester Klaburner						llian Mo				
, Mai	and 2 short Health and tem 27 is n		19a. Informant's Name/Relationship (T) Joseph E. Sedlak (er or Rural Route Baltimo				
Baltimore,	_ P = 7		20a. Method of Disposition 1 ☐ Burlal 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		20b. Place of Commetery, Bayview	isposition (N crematory or Crema	ame of other place tory	Inc.,	Date 10/24/20)11 I	Oc. Location		wn, State Maryland
Balt	permit. Page Department Important: any injury o		21. Signature of Funeral Service Licens	Rousko	,	22. Name a	dzins	s of Facilit	neral H	ome P	.A.	·	and 21221
0	Physician/ Medical Examiner physician and p	ical Examiner	23a. Part 1. Enter the disease, or competions, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c.	. (iatic	- 1		scular	-			Approximate Interval Between Onset and Death
O. Box 6876	To true hospital or Attending Physician; The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the incompletely filled in by the funeral director.	_	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at 9 Unknown	2 Fetal death time of death	3 ☐ Ectopic 5 ☐ Other (specify)				_ I	te of delive	ery Day Year
ls, P.	uires that n signed uld be de	۵	Part II. Other significant conditions or	ntributing to death bu	ut not resulting in	he underlying	cause give	en in Part I	1. 23				e cause of death?
Division of Vital Records, P.O.	: The law rec cate has bee	Completed								a. Was an autopsy perform Yes 2		Were autor orior to cor death? 1 Yes	osy findings available mpletion of cause of
Vita	iysician; The lis certificate director, pag	To Be	25. Was case referred to medical examiner? Yes 2 \sum No	lospital:	ent 2 🗆 ER/Outp	atient 3 🗆 [Otho	×1	th (Check only or ursing Home 5)		ce 6 \(\text{Other}	er (Specify)	
on of	ath. r: After th ne funeral		27. Manner of Death 1	28a. Date of injur (Month, Day,			28c. Injury work? 1 🗆 \	at	28d. De		injury occurr		
Divisi	al or Atte s after de Il Directo ed in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injuit building, etc.		street, facto	ry, office			cation (Stre y or Town, S		er or Rural	Route Number,
_	to the Nospital or Autending Physician; The la within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check (Check only one) 3. Certifying Phys	cian: To the best of r er: On the basis of ex e Practitioner: To the	amination and/or in	vestigation, Ir	my opinior	n, death oc	curred at the time	e, date and	place, and due	e to the cau	ise(s) and manner stated
	Northi Corri		29b. Signature and title of certifier) 1/2 Su	4		c. License		7		d. Date signed	d (Month, E	
		1	30. Name and address of person who co	ompleted cause of de	ath (Item 23a) (Typ	e, Print)	7.4	the	11/2	MJ	210	G D	1 20 -1
	Stat Registra	~	31. Date filed (Mynth, Day, Year) OCT 24 2011	32. Registral	's Signature	Red	Ly	., ~)	vinel	- 6	~~~	V	

DHMH 17 Rev 06-2011

11-07551 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Nicholas Everett Delosantos State of Maryland / Department of Health and Mental Hygiene 33721 1- For State Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month October 8, 2011 **Medical Examiner** 2210 hrs NICOLAS EVERETTE DE LOS SANTOS 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9204 Red Bridge Court Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Foreign MARYLAND Country) Months Director 577-29-7455 Days Hours 14 FEB 27 1997 1X M 2 F Yrs Usual Residence of Decedent III 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location s 23a or 28a-f show e notified at once. HOWARD LAUREL 1 Yes 2 No hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 喜 9204 RED BRIDGE COURT 20723 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Yes 5 BLACK 3 Widowed 4 Divorced f Yes, Give Year Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural". 1 X Yes 2 No specify: DOMINICAN Specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 9TH STUDENT Student 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) CESAR DE LOS SANTOS ANGELIQUE ROGERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 9204 RED BRIDGE COURT, LAUREL, MARYLAND 20732 ANGELIOUE MARTIN/ MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10/18/2011 LANDOVER, MARYLAND HARMONY CEMETERY 4 Donation 5 Other Specify: Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME aphney 7474 LANDOVER ROAD, LANDOVER, MARYLAND 20785 23a. Part Denter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a. Hanging Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and Physician/Medical the attending physician ed for use as the burial -UNPENDED \mathbf{x} AMENDED 16b per fh g920 10-24-11 vt Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death 2 Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown icate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed' death? ✓ Yes 2 No certificate 1 🗸 Yes 2 No the Hospital or Attending Physician; 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 V Other: Scene DOA After this 1 🗸 Yes 28a. Date of Injury FOUND: Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Subject hung self 1 Natural FOUND 5 Pending Director: 1 Yes 2 ✔ No Oct 8, 2011 2159 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide 6 Could not be determined 24 hours a (Specify) Single Family Home 9204 Red Bridge Court, Laurel, MD 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 9, 2011 all 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State egistrar's Signatur eneur

DHMH 17 Rev 1/2001 **OCME 2006**

Registra

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Octo ber Physician/ Cynthia D. Simmons Medical 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** 4b. City, Town, or Location of Death Prince Regional Hospital aurel -aure 8. Date of Birth
(Month, Day, Year)
4, 1958 If Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 6. Sex **Funeral** 7. Age (In yrs. last birthday) 1 □ M 2 👿 F Hours **Director** 217-70-1282 53 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 1 X Yes 2 □ No MD Baltimore 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21217 1711 N. Calhoun Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō Completed by 1 Never Married 2 Married 1 Yes : 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", 3 Divorced black Year or Dates er than "natur the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) บท 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. parking control marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Louis Simmons Sr Suzanne Frances Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Juanita M. Simmons/daughter 2842 Parkwood Avenue Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) 21. Signatule of Euneral Service Licensee ²State Anatomy Board 655 W. Baltimore Street Raltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate C (Final disease or condition Onset and Death

Months HIV Infection Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner fomegalovirus Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 1 ☐ Live Birth 4 ☐ Pregnant : 9 ☐ Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Old Stroke 1 Yes 2 No 3 Probably 4 Unknown Anorexid 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Respiratory Failure Yes 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Tes 2 No Accident Investigation □ Acciden
 □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Box 68760 P.O. Division of Vital Records, To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9101

Pritam S. Saini MD

Date filed (Month, Day, Year)

D28998

Laurel

Cherry Lane, Suite 211

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Sulaiman Salaam		1- For State Registrar		Maryland		artment of <i>rtificate of</i>		ind M	ental H	-	Reg. No.	201	1 33723
Physiciai Medical Examin			e (First, Middle,Last)							2. Date of Dea Month	Day	Year	3. Time of Death 1616 hrs
uruur Examin.			n Salaam if not institution, give str	eet and number	r)	-	b. City, Town,	or Locati	ion of Death	October 1		ounty of De	
		7907 Trapp		<u> </u>			Dundalk					Itimore C	•
Funeral Director		5. Social Security N	Number unk 6. Sex			ast birthday)	if Under 1 Y Months D		Jnder 24Hrs ours Min.			9. I For	Birthplace (State or eign NOTTh
	ŀ	Usual Residence o	1 X M	2F	- 6	1 Yrs.				Sept 2	2, 195	50	CountryCarolina
y any	Ì	10a. State	10b. County	1/2	10c. City,	Town or Locati	on			-			10d. Inside City Limits
·land -f shor	ğ	MD	Baltimore	9		Dunc							1 Yes 2 No
or 28a	Director	10e. Street and Nu 7907 T	mber rappe Road				10f. Zip Code	2122:	2	1	10g. Citizer	of What Co USA	ountry?
21215-0036 Ide of filed within 72 hours after death with the Maryland dental Hygiene. arked other than "natural", or items 23a or 28a-f show any event, the Medical Examiner must be notified at once.		11. Marital Status	12	. Was Deceden			Decedent of I	Hispanic	Origin? (Sp	ecify Yes or No	D- 14		erican Indian, Black,
r death	Funeral		ed 2 X Married		? 2 X No		es, specify Cub			Rican, etc.)		White, etc.	
nrs afte	⋧ .	3 Widowed 15. Decedent's Ed	4 Divorced of Specify only his	Pates:	mpleted)	1 16a. Decedent	Yes 2 χ h			vork done		becify: b	1ack
72 hor	Completed	Elementary/Seco		College (1-4 or			ost of working l					- 17	
within giene.	틹	17 Fotboda Nomo	12 (First, Middle, Last)	0		dr	iver	Lanua		(F) 1 3 2 1 U			transit
21215-0036 Juld be filed within 7 Mental Hygiena marked other than te event, the Medica	86 C	Curtis						10.100	mers Name	(First, Middle,	Maiden Su	irname)	
21 hould I nd Mer is mar		19a. Informant's Na	me/Relationship (Type,	Print)		19b. Mailing	Address (Str	eet and I	Number or R	tural Route Nur	mber, City	or Town, Sta	ate, Zip Code)
and 2 showed tem 27 is traumatic	ŀ	Gail Sm 20a. Method of Disp	ith/spouse		20b. F	323 I1 Place of Disposi	ving T	urne	r Blvo	l Newar	k, NJ	0710	8 or Town, State
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.			Cremation 3 F		tate (crematory or oth							
altin mit. P partme porta	ŀ	4 Donation 5 21. Signature of Fu	X Other Specify: 1 neral Sice Licensee Sign	n state	ootor	22. N	ame and Addre	ss of Fac	cility	1 (55 1	1 D 3	1	e Street
10.2	Ł	10000	11/11	M		i Ba	Ltimore	, MD	212	01			
Physician /Medical		ailure. List on	e disease, or complicati ly one cause on each li	ne.						respiratory arr	est, shock,	, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (or condition resultir		to (or as a cons		erotic Cardio	ovascular L	isease	,				
		Sequentially list con if any, leading to im	nditions, b	to (or as a cons	equence of	f):							
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50, te be executed sysician and burial - transit	edical Examiner	UNPENDED		MENDED									
Box 68760, c death certificate be the attending physici of for use as the buri	- 1	F FEMALE: 3b. Was decedent past 12 months	pregnant in the	C. If yes, outco	me of pregr		al death 3	Ecto	opic pregnar	псу		ate of delive onth	ery Day Year
Ox 6876 (eath certificate eath certificate eath certificate for use as the li	Muysician,		lo 9 Unknown 9	Pregnant at	time of de	ath =	er (Specify)				Ì		_
. 8 7 8 8		Part II. Other signif			h but not re	esulting in the ur	nderlying cause	given in	Part I.	23e. Did to	obacco use	contribute t	to the cause of death?
s, P.O. nires that the signed by doe detack	20 00									1 Yes	3 2 N	o 3 Pr	obably 4 🗹 Unknown
of Vital Records, ng Physician: The law require. The this certificate has been sineral director, page 2 should be a feed of the certificate has been sineral director.	paradulos			·····						24a. Was autop	sy		autopsy findings available completion of cause of
tal Rec		05 Mar								1 Yes	rmed? 2 ✔ No		Yes 2 No
Vital Rec ysician: The his certificate director, page	Δĺ	25. Was case referr examiner? 1 ✓ Yes	ed to medical Hospit	tal: 1 Inpatie	ent 2	ER/Outpatient	_	-	ath (Check o	Home 5	Residence	6 ✓ Oth	er: Scene
n of Vi		27. Manner of Death		28a. Date of Inju (Month, Day,)	iry 'ear)	28b. Time of In		jury at W	ork?	28d. Describe h			
Division fal or Attendi rs after death. al Director: A led in by the fu		2 Accident	5 Pending Investigation	00- 81				Yes 2					
Division o spital or Attending spital or Attending sours after death. neral Director: After filled in by the fune		3 Suicide 4 Homicide	6 Could not be determined	(Specify)	ijury - At no	ome, farm, street	, factory, office	building	, etc.	or Town, S		Number or h	Rural Route Number, City
0 - 8 -	_ 1 4	29a. Certifier 1	Certifying Physician: 7 Medical Examiner: On t										
To the H within 24 To the Fo completel	2	29b. Signature and	and	manner stated.			29c. Licer			,			onth, Day, Year)
		anes	2				0.0	.М.Е.			Octobe	er 19, 201	11
	3	0. Name and addre	ess of person who comp MD. Assistant M	_			nore Street	Raltin	nore MD	21223	•	- 1	
Stat	e s	1. Date filed (Monti		2. Registra				, Dailill	IIOIG, WID	21223			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:25 PM Medical 201 Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City Town, or Location of Death 10 Town If Under 24 Hrs 6. Sex 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 972 Min **Director** 1 🔀 M 2 🗆 F May 17. mar 28a-f show 10b. County with the Maryland 10a. State 10c. City, Town or Location the Medical Examiner must be notified at Director Yes 2 No 10e. Street and Number or 10f. Zip Code 10g. Citizen of What Country Funeral items 23a 2 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonce. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 2 No If Yes, Give 7 Year or Dates. -Specify 3 Widowed 4 Divorced (acl Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0,12) College (1-4 or 5+) Apok Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ S 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 824 2121 20b. Place of Disposition (Name of cemetery crematory or other place) 20a. Method of Disposition Date 20c. Location -City or Town, State 1 ☐ Burial 2 ☐ Scremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Licensee Enter the disease, or complications that caused or heart failure. List only one cause on each line. not enter the mode of dring, such as cardiac or respiratory arrest sease, or complications that caused the death. Approximate
Interval Between
Onset and Death Immediate Cause Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year 1 Yes 2 9 Unknown Pregnant at time of death Day Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖟 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 6 Other Specific 21 No Hospital Other: ٩ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 ANatural 5 Pending work Accident 1 Tes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, only one 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 1004337 ress of person who completed cause of death (Item 23a) (Ty MERRICT 2835 31. Date filed (Month, Day State

Registrar

OCT 24

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#2perpHYS, G921, III, 17/2011, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar 33725 Reg. N Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16 20 11 Physician/ OCTOBER 7:54 PM **ESTELLA** SHARP Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S BOWIE BOWIE HEALTH CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X Min. Days Months Hours NORTH CAROLINA Director 78 577-44-3360 $\widetilde{1}933$ Usual Residence of Decedent 23a or 28a-f show 10b. County the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD PRINCE GEORGE'S LANHAM 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5524 AMBER STREET 20706 USA Was Deceue... Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Black, White, etc ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: BLACK 1 Yes 2 X No Specify: "natural", Completed 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th GOVERNMENT marked other LPN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ ALBERT BAGLEY SR. QUEEN VICTORIA MCFARLAND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 permit. Page 1 and 2 sl: Department of Health ar Important: If item 27 is any injury or other trau ANGELA MADAGU/DGT. 12007 BLAKETON STREET UPPER MARLBORO, MARYLAND 20774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) RIVERDALE CREMATORY : 10-24-11 RIVERDALE, MARYLAND re of Functa Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Reene 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. In er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Obset (Fibal) Onset and Death Physician/ disease or condition resulting in death) CARDIOPULMONARY ARREST Medical Due to (or as a consequence of **Examiner** ACUTE ASPIRATION PNEUMONITIS Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): DYSPHAGIA that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) inding physician ause as the burial-Physician/Medical ALZHEIMERS DISEASE IF FEMALE: nse yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MORBID OBESITY Records, To the Hospital or Attending Physician: The law requires 2 № No 3 □ Probably 4 □ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an OBSTRUCTIVE SLEEP APNEA HYPOVENTILATION autopsy page performed? Yes 2 No CONGESTIVE HEART FAILURE 1 ☐ Yes 2X☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 XNo Other: မ 1 Inpatient 2 K ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 24 hours after death. Funeral Director: A Accident Investigation the within 24 hours after dex To the Funeral Director completed filled in by th Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year, MD D32654 OCTOBER 17, 2011 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p JOHN SERLEMITOSOS M.D. 2033 PENDERBROOK DRIVE CROWNSVILLE, MARYLAND 21032 31. Date filed (Month, Day, Year) 32. State 4 Registrar

Box 68760

P.O.

Division of Vital

CHARLES H. SHEPPERSON 10/18/2011 2049PM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. N 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 20491 201 Medical 4a. Facility Name (if not institution, give street and nur Town, or Location of Death 4c. County of Death **Examiner** Kesville Salto If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min 520 58 Director Usual Residence of Decedent 10c. City, 10a. State 10b. County with the Maryland 10d. Inside City Limits notified at Director 28a-f ikesv 1 🗌 Yes 2 🖳 🗥o 10e. Street and Number r items 23a or iner must be n 9 10f. Zip Code 10g. Citizen of What Country? Funeral 2/208 220 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ö þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Black "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Nu or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. LEVUNI 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other p 1 ☐ Burial 2 🗲 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-26-2011 22. Name and Address of F Funeral Service 1935 1701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tenioscleratic Condiovascular Disease Physician/ pertensive Ar disease or condition Medical resulting in death) ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) Cause (Disease or linjury that initiated events resulting in death) Last burial-transi attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death
Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≙ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 2 No Accident Investigation
6 Could not be 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. d title of certifier 18661 toben 19.2011 30. Name and address of person who completed cause of death (kem 23a) (Type, Print) 1 GM, PHILL P MILLITELLO GTRIMBLE HILL CTLUTHERVILLE, MD 21093 31. Date filed (Month, Day, Year) 32. State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Frederick Schaub R. 12:10a ^M October 20, 2011 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. . Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 212-58-7170 **Director** 1 🙀 M 2 🗆 F 60 Maryland Usual Residence of Deceden April 14,1951 28a-f show 10a. State notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PA York Fawn Grove 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 535 Garvine Mill Road 17321 USA or items 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. þ 21215-0036 1 Yes 2 No Specify. "natural", White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than " Page 1 and 2 should be filed within ment of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Fireman Baltimore City 12 years is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Frederick William Schaub Doris Roman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau Lucinda Schaub Wife 535 Garvine Mill Road, Fawn Grove, PA 17321 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

✓ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Of Jesus Dundalk, Maryland 25, 2011 Signature of Funeral Service Licensee Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiomyona Physician. disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events v mon an and the burial-tra Due to (or as a consequence of resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy sidemia 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case ref Be 26. Place of Death (Check only one) examiner? 1 \(\sum \) Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be within 24 hours after deat To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, 0-41399 30 Nam ompleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

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North Point Blud Ball.

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		•	For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of l rtificate of l		na Mental Hy	ygiene Reg. N 2 (111	33728
	Physicia	in/	Decedent's Name (First, Middle, Las Lula Mae Tincher	,				2. Date of D	Death	Year	3. Time of Death
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-			Stella Maris Hos 5. Social Security Number 6. So			If Under 1 Year	imonium			Baltimo	
	Funeral Director		213 26 3537		(In yrs. last birthday) Yrs.	Months Days		Hrs. 8. Date of B (Month, E) Nov. 7	Day, Year)	9. Birthpla Country West	
	and show fat	jo.	Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town or Lo						d. Inside City Limits
	e Maryl r 28a-f notified	Direct	Maryland Baltimo	re	Middle	River					1 Yes 2 X No
	with th	Funeral Director	6 Bay Ct.			10f. Zip Code 21	220		10g. Citizen	of What Countr USA	у?
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ह	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Wildowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 If Yes, Give Year or Dates.	No.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🔀 No		? (Specify Yes or No uerto Rican, etc.)		Race - Americal Black, White, et cify: White	tc.
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land	be filec ental H rked otl ic even	To Be	17. Father's Name (First, Middle, Last) Carl Johnson					Name (First, Middle Moore	e, Maiden Surr	ame)	
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Baltimore,	age 1 ar int of He t: If iten 7 or oth		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐		20b. Place of Dispo cemetery, crer Holly Hil	nsition (Name of matory or other pla	ce) rdens 1	Date 0/26/2011	20c. Locati	on - City or Tow	n, State
altin	permit. Pa Departme Importan any injun		4 ☐ Donation 5 ☐ Other (Specifical Service License) of Funeral Service License					eral Home		more, is	
	2 G E 2 9		23a/Part 1. Enter the disease, or comp	Kruske		407 Old	Faster	n Avenue	Essex,	-	nd 21221 Approximate
	Physician/		Immediate Cause (Final disease or condition	ne cause on each line		or the mode or dyn	ng, saon as car	and of respiratory t	arrost,		Interval Between Onset and Death
- Jane	Medical Examiner		resulting in death)		consequence of):			•			
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Box 68760	Hospital or Attending Physician: The law requires that the death certificate be executed the hours after death. Funeral Director: After this certificate has been signed by the attending physician and ately filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live Birth of 1 ☐ Pregnant at 1 ☐ Unknown	2 Fetal death 3	Ectopic pregnan Other (specify)	су		23d	. Date of deliver Month D	y Day Year
P.O.	that the ned by e detac	y Ph	Part II. Other significant conditions co	ontributing to death be	ut not resulting in the υ	nderlying cause g	iven in Part I.	23e. Díd	tobacco use o	ontribute to the	cause of death?
rds,	equires een sig hould b	eted							Yes 2XN		ably 4 🗆 Unknown
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Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, str . <i>(Specify)</i>	eet, factory, office			(Street and Nu own, State)	mber or Rural R	loute Number,
	e Hosp 124 hou e Funei detely fi	Medical	(Check 2 Medical Exami	ner: On the basis of ex	my knowledge, death of amination and/or investobet of my knowledge,	tigation, in my opini	ion, death occu	rred at the time, date	and place, and	due to the caus	se(s) and manner states
_	To the within 2 To the comple		29b. Signature and title of certifier	0 1 10		29c. Licens				gned (Month, Da	ay, Year)
			30. Name and address of person who co	ompleted cause of de	eath (Item 23a) (Type F	Print) KI	44 14	_	[0]	21/201	1
-			JACKIE JONES, CR	NP 2300 1	DULANEY VA		TIMON	IUM, MD 2	1093		
	Sta Registra		31. Date filed (Month, Day, Year) QCT 24 2011	32. Registra	r's Signature	es!					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink Fasure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 | For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0/13/201 Physician/ 5:40 P_{M} Brenda Kay Thompson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Co. Timonium Stella Maris If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year 1960 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral Director** 216-76-2057 1 🗆 M 2 👿 F 3/18/2011Yrs 51 MD Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director Timonium 1 Yes 2 No Co Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral USA 21205 820 N. Linwood Ave. items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces?
1 ☐ Yes 2 🙀 No Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give "natural", Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry n and Mental Hygiene.

7 is marked other than "r traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) **N/A** Factory Laborer Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Leonard Thompson Tommie C. Daniels Page 1 and 2 should be ment of Health and Menta traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. MD 21213 Ebony Saunders-Daughter 2602 Mura St. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10/21/201 Randallstown, MD 4 Donation 5 Other (Specify) King Memorial Pk. 22. Name and Address of Facility March F/H 1101 E. North Signature of Funeral Service Licenses Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications to a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician **HUMAN IMMUNODEFICIENCY VIRUS** disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). executed the burial-tran and Due to (or as a consequence of) physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 👿 No Day Year Pregnant at time of death 5 Other (specify) be detached the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy performed After this certificate Yes 2 V No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Tother (Specify) HOSPICE 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ျ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred iniury 5 Pending X Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 U Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) By 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 JUNECIA WHITE, Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

2 4 2011

2011

OCTOBER 13,

BRENDA THOMPSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Robert T. Venev AM 5:18 10 2011 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GOOD SAMARIJAN HOSPIJAL N/A Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**√** M 2□ F Days Hours Min 214-64-3803 Director MD 8/22/1954 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location id other than "natural", or items 23a or 28a-f shovevent, the "hedical Exprimer must be notified at 28a-f show 1 Yes 2 No Director N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6040 Harford Road 21214 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "nature" any injury or other traumation. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☑ Never Married 2 ☐ Married Black 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Of Maryland Clerk 2yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oren M. Veney Christine Perry ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4121 Coleman Ave. Baltimore, MD 21213 Christine P. Veney-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemt. 10/24/201 | Lansdown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March 1101 E. North F/H Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Left lung preumania /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) executed attending physician and for use as the burlal-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 | Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an s certificate has t lirector, page 2 s autopsy performed? the Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Thpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Susedi, MD 2011 RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANAMA SUBEDI MD, S601 Lock Raven Bird. Baltmare MD. 21239. 31. Date filed (Month, Day, Year) 32. Registrar's Signature fact State OCT 2 4 2011 Registrar

ORERT

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 2011 Francine Denita Williams Month 08:30AM octoben Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 XF 56 217-64-5330 **Director** /1954 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21218 1820 E 32nd Street 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Placement Counselor 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dorothea Davis William Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. Williams-Husband Jack Street Baltimore, MD 21225 957 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery crematory or other place King Memorial Pk. 10/24/2011 Randallstown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H 1101 E. Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician Sickle cell Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Severe anemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Seores and burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No ō Month Day Year Pregnant at time of death signed by the aid be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş thrombocytopenia, HCV, ESKD 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 s autopsy performed' death? certificate 2 No 2 N Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 \square Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 3 \subseteq Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier A72438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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31. Date filed (Month,

Union

32. Registra

Memorial Hospital Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3, Time of Death 1. Decedent's Name (First, Middle, Last) OCTOBER 1^{Day} 201 1^{ear} 4:26 PM Physician/ JOYCE WILLIAMS Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner PRINCE GEORGE'S BOWIE BOWIE HEALTH CENTER 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 5. Social Security Number Funeral SEPT. 26 1 □ M 2 🏖 F Months TEXAS 1940 449-68-4738 71 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location 10a. State death with the Maryland the Medical Examiner must be notified at Director 1 😾 Yes 2 □ No MD PRINCE GEORGE'S SPRINGDALE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō or items 23a Funeral USA 3905 20774 92nd AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 1. Marital Status Black, White, etc. ģ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. Baltimore, Maryland 21215-0036 BLACK 1 🗆 Yes 2 🛣 No If Yes, Give Year or Dates Specify. Specify. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT TEACHER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ ANNIE L. DENSON HENRY LEE CYRUS SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CHANDRA CARTLEDGE/DGT 1010 CHILDRESS TRAIL LUSBY. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 10/25/11 LANDOVER, MARYLAND HARMONY CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of June a Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heaft tigliure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician/ CARDIOMYOPATHY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence on, To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DIABETES TYPE 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 X No within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, page 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? 1 🗆 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 ID DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

31. Date filed (Month, Day, Year) State

only one)

29b. Signatan and title of certifier

4

Name and address of person who completed cause of death (Item 23a) (Type, Print)
PERRY WEISMAN M.D. 15001 HEALTH CENTER DRIVE BOWIE, MARYLAND 20716 Registrar's Signat

DHMH 17 Rev 7/2009

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

2011

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2:20am M 2011 October Medical JAMES WILSON WILLIAMS 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE CO TOWSON GILCHRIST HOSPICE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) **Director** 218-60-4020 1 XXM 2 🗆 🛱 58 Yrs. CONNECTICUT 1953 2, Usual Residence of Decede Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. But if item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10a. State 10c. City, Town or Location Director 1XXYes 2 No BALTIMORE MARYLAND N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21218 U.S.A. 2615 GARRETT AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces?

1 Yes 2 XXIo þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: BLACK Completed 3 Widowed 4XXDivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SELF HANDYMAN 12yrs Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ AUGINS JAMES WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 2615 Garrett Avenue, Baltimore, Md., LaShelle E. Williams/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10-22-11 BALTIMORE, MARYLAND KING MEMORIAL PARK Name and Address of Facility LLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 206 W NORTH AVENUE 21. Signature of 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ptaysician/ PARCE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last and for use as the burial-tran Due to (or as a consequence of): nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal deal 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) been signed by the a should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 1 Yes To Be Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy prior to completion death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, 25. Was case referred to andical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA After this 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 5 Pending
Investigation Natural work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			State Registrar		•		tificate				Reg. N. (337	34_
п	Physicia	en/	1. Decedent's Name (First, Middle			_				2. Date of Dea	ath Day_	_ Ye	ear .	3. Time o	
100	Medic	cal	Raymond H. 4a. Facility Name (if not institution	Beitzell, Si	· ·		4h City To		Location of Death	Septemb		, 20 ounty of	_	2:0	7 P ^M
أرب	Examir	ner	Holy Cross I 5. Social Security Number	Hospital	e (In yrs. last birti	b stoy d		ver	Spring If Under 24 Hrs.	☑ 8. Date of Birl	Mo	ntgo	mer	Y place (State	or Foreign
P	Funeral Director		579–36–0426 Usual Residence of Decedent	1 X M 2 D F	, ,	Yrs.		Days	Hours Min.	01/02/1		N.	Count	ingto	n,D.C.
	show dat	ρī	10a. State 10b. County		10c. City, Towr	or Loc							1	0d. Inside C	Dity Limits
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Baltimore,	permit, Page 1 a Department of I Important: If ite any injury or ot		21. Signature of Funcial Service	icense		22	. Name and .		s of Facility Crain Hw	Beall E					
П			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each line	the death. Do n	ot ente	er the mode of	of dying	g, such as cardiac	or respiratory ar	rest,			Approxima Interval Be	etween
~	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	_ a Hypero	apnic H		xemic	Res	piratory	Failur	e			Onset and	1 Death
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Box 68760	Attending Physician: The law requires that the death certificate be #reau actor. After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death		Ectopic pre Other (spec		у		23	d. Date of Month		ery Day	Year
P.O.	hat the ed by detack		Part II. Other significant condition	ons contributing to death b	ut not resulting i	n the u	nderlying ca	use giv	en in Part I.	23e. Did t	obacco use	contribu	ite to th	ne cause of	death?
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Re	sician: The law certificate has l irector, page 2 s									1 🗆 Yes	2 No		th? Yes	2 🗌 No	
ita	slcian certifi irector	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	o □ 50/0.			Othe	ace of Death (Chec			1 041	· · · · · · · · · · · · · · · · · · ·		
of \	g Phy er this neral d	te: To	27. Manner of Death	28a. Date of inju	ent 2 ER/Ou	ripatier Fime of njury		c. Injury	at	ome 5 Resi			Specify		
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Division of Vital	To the Hospital or Attending Physician: Navinin 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	al Certificate:	4 Homicide determ	ined 28e. Place of Inju- building, etc	: (Specify)					28f. Location (City or Tov	vn, State)				nber,
	ne Hospital or in 24 hours afte ne Funeral Dir pleted filled in	Medical	(Check 2 L Medical I	Physician: To the best of examiner: On the basis of e Nurse Practioner: To the	xamination and/o	r invest	tigation, in my	y opinio	n, death occurred	at the time, date a	and place, a	nd due to	the ca	use(s) and n	nanner stated.
	To the Zawithin 2 To the Comple		29b. Signature and title of certifie	0.11.1			29c. l	License	number		29d. Date	_			111
	1011		20 Name and address from	who completed assess of	eath (Itam 20a)	Time F	Print)	OO	bt 27	7	Sept	embe	er 2	28, 20	
	10+1		30. Name and addrescof person Veerappan Alac	arsamv. Holy				, 15	500 Fores	st Glen	Rd. S	ilve	r S	2 princ	20910
	Sta	te	31. Date filed (Month, Day, Year)	2011 32. Fegistra	ar's Signature	1	- 11 1								

Registrar

DHMH 17 Rev 06-2011

State

MARILA

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

68760

Box

Division of Vital Records,

2001 Medical Parkway, Annapolis, MO 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

VILLANUAY, MD

OCT 05 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death A 1. Decedent's Name (First, Middle, Last) October IFÖS Physician/ 1245 Carol Diane Bailey Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Washington Hagerstown Meritus Medical center If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday) Social Security Number **Funeral** 1 □ M 2 ₹ F Months Days Hours August 30, 1955 Pennsylvania 56 Director 220-64-2044 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2 🛭 No Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral USA 21742 13522 Foxfire Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 14. Race - American Indian. 11 Marital Status Black, White, etc ģ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ^{Specify:} White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Office Billing Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Charlotte Louise Miller Ralph Eugene Stickler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13522 Foxfire Lane Hagerstown, Maryland 21742 Alvin N. Bailey 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Greenlawn Mem. Park Oct.12,2011 | Williamsport, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Osborne Funeral Home P.A. of Fuperal Service MD 21795 425 S. Conococheague St. Williamsport, 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final ing carrinoma Physician/ Moniks disease or condition resulting in death) Medical Due to a as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death Day been signed by the atte should be detached for in the past 12 months? Month Year Pregnant at time of death 2 No Yes Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? Yes 2 No death? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) ျ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Memzen 028365 10-11-11 who completed cause of death (Item 23a) (Type, Print) Strat Hagerston MD 21740 368 ANZAR HAFT 5 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma		epartment of t Certificate of			gierre Reg. No.		33731
	Physicia	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	Day		3. Time of Death 3:35 A M
	/Medic	al	Rebecca 4a. Facility Name (If not institution, give		kburn	4b. City, Town, o	or Location of Death	OCTOBE		9, 2011 County of Death	7.57 A
	Examin	ei	1 . 0 - 1	BELAZI	R	BEL	AIR			HARF	
	Funeral Director		5. Social Security Number 6. Security Number 215-12-8744	TAL SOUTHER	e (In yrs. last birth	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 7/23/1	y, Year)	Cou	
pur	>		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				1	10d. Inside City Limits
Maryla	f show	tor	MD Harf	ord	Bel Ai						1X es 2 □ No
th the	or 28a	Director	10e. Street and Number			10f. Zip Code			0	izen of What Cou	ntry?
ath wi	s 23a	erail	1909 Emmorto		Constitution 110	21015			JSA	14. Race - Ameri	can Indian
u c i c i 3-0000 filed within 72 hours after death with the Maryland	if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinationst be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:		13. Was Decedent of I If Yes, specify Cub		o Rican, etc.)		Black, White,	
hin 72 ho	e. an "natur Medical	Completed	15. Decedent's Ed (Specify only highest grades Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of world	king		ind of Business/Ir	
ed with	lygiene ver tha rt, the			2		Nurse	18. Mother's Nam	e (First Middle		vil ser	vice
d be fil	ental H	o Be	17. Father's Name (First, Middle, Last) Manuel Huf	fman			Claire			Gumamey	
should be	n and Mental Hygiene. is marked other than raumatic event, the My	٦	10. July manufa Nama (Balatianahia /	Sma Drint)	19b.	Mailing Address (Stree	t and Number or Ru	ıral Route Numb	er, City o	or Town, State, Zi	ip Code)
and	of Health a f item 27 is r other tra		Peggy Blackburn	- daught	eraw 2	314 Carlo	Rd.,Fa	llston	, MI	21047 ocation - City or T	own State
Pag	Department of Health Important: if item 27 any injury or other tr once.		1 ★ Secretary 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	Bel A	Disposition (Name of y, crematory or other pla Ir Mem GC	i	2/2011	Be.	l Air,M	
permit.	Depar Impor any in once.		21. Signature of Furjery Service Licen	Gusa		22. Name and Addr Harkins F	H.Inc.			17314	
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pe	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence o	f):					
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icate be	physicia the bu	edical		d							
the death certif	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)				23d. Date of deli Month	ivery Day Year
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1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ificate or, pag	e Cor	25. Was case referred to medical				26. Place of Dea		ormed2 2 N	o 1 ☐Yes	2 □ No
l VIII	iis cert directo	m	examiner?	Hospital: 1 ☐ Inpati	ent 2 ER/Ou	tpatient 3 DOA				6 ☐ Other (Spe	cify)
ding P	h. After th funeral	tion:	27. Manner of Death 127. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da		ime of 28c. Injury Wo	ury at ork? ⊒Yes 2 ⊒No	28d. Describe	how inju	ary occurred	
JVISI	after deatl Director: d in by the	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e, Place of In	jury - At home, fai tc. <i>(Specify</i>)	rm, street, factory, office		28f. Location City or To	(Street a	and Number or Ru te)	ural Route Number,
e Hospita	24 hours Funeral etely fille	Medical C	29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best niner: On the basis and manner si	of examination an	e, death occurred at the d/or investigation, in my	time, date and place y opinion, death occ	e, and due to the curred at the time	e cause e, date a	(s) and manner a nd place, and due	s stated. to the cause(s)
o ţ	within To th соттр	Me	29b. Signature and title of certifier	~		29c. Lice	nse number		29d. D	ate signed (Mont	h, Day, Year)
1	,		Jullyan	MD		Da	15344		10	119/20	[/
\	CY		30. Name and address of person who	completed cause of	6 22 5, i	Type, Print) LOVION AVE BANN	HAVRE	DEGRA	CE,	140210	7.5
	Sta Registi		31. Date filed (Month, Day, Year) OCT 2 1 20	11 Deter	rar's Signature	barker					

BLACK BURN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ cona eptember 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Burnie Glon Baltimore Washington medical Anne Arunde 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 52 1 M 2 XF Months sept.07, 1959 219-74-4546 Maryland Director ms 23a or 28a-f show must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Severn 1 🗆 Yes 2 🎗 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1839 Meade Village Circle Road 21144 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Examiner Black, White, etc. ō þ 1 X Never Married 2 Married ☐ Yes 2 💢 No Yes, Give Saltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White "natural" Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene.
7 is marked other than "r Clark, Leona Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William C. Clark Agnes A. Ryan 19a. Informant's Name/Relationship (Type, Print) Bb. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 634 Chapelview Drive Odenton, MD 21113 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Kathryn Clark/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept 30, 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 2011 Metro Crematory, INC. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee cremation Direct 495 Ritchie Hwy Severna Park, MD 21146 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 54BAMACUMOSO Physician disease or condition resulting in death) UCMOMMAGE-Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician a hed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform 24 hours after death.

Funeral Director: After this certificate leted filled in by the funeral director, page 1 ☐ Yes 2 ☐ No ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manper of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of ce

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (M

UOS 11m

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WASUINGOON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Cher 0545AM Crow1 Medical Martin 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington <u>Meritus Medical Center</u> <u>Hagerstown</u> 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Hours 1 🕅 M 2 🗆 F Maryland Director 217-16-2958 90 March Usual Residence of Decedent show iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Maryland Washington <u>Keedysville</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5222 Hollow Tree Lane <u> 21756</u> U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 X No Specify: If Yes, Give "natural", White Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Railroad Company <u>ocomotive Engineer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Fink Harry Μ. Crowl, Sr. Cora Μ. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vaughn D. Crowl/ Nephew 18818 Fountain Terrace, Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brownsville Hghts Cem 10/11/2011 Brownsville, Maryland 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 21. Signature of Funeral Service Licensee 7606 Old National Pike, Boonsboro, Maryland 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Muchi disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence o cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 No signed by the a d be detached f 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death.
Funeral Director: After this certificate has b autopsy 1 Yes 2 No Yes 2 N sompleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d, Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JW- 15 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) John Edward CANFIELD, Sr. October 7 ay 2011 Year Physician/ 18:10AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington **Examiner** Hagerstown 16919 Fairview Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** (Month, Day, Year) ec. 29,1935 1 🙀 M 2 🗆 F Mary land 217-30-6570 75 Director Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Hagerstown Maryland Washington 1 Yes 2X No 10e. Street and Number 10g. Citizen of What Country? Funeral 16919 Fairview Road U.S.A. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: white If Yes Give 3 Widowed 4 Divorced 1957 Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) self employed masonry contractor Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ျှ Brandt Viola Henry Harrison Canfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 16919 Fairview Road, Hagerstown, Maryland Hilda Canfield - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Cedar Lawn Memorial
Park 1 X Burial 2 Cremation 3 Removal from State October 1 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Minnich Funeral Home Signature of Funeral Service Licenses 22. Name and Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Vear Pregnant at time of death 1 Yes 2 9 Unknown the 9 Unknown detached After this certificate has been signed by uneral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Hunknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 VNC 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 □ Yes 2 □ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 24 hours after death. Funeral Director: A Accident Suicide Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2 10/10/2011 lame and address of person who completed cause of death (Item 23a) (Type

State Registrar egistrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mothy Milton D		State of Maryland For State Registrar Ammended Box 5 Per FD WSH		nent of		Menta	l Hygi		201		33741
Physicia	n/	Decedent's Name (First, Middle,Last)						ate of Death	Day Year	3.	Time of Death
dedical Examir	ner	Timothy Milton Deal			b. City, Town, or L		0	ctober 3,	2011 4c. County of I)ooth	1914 hrs
		4a. Facility Name (if not institution, give street and numbe Carroll Hospital Center	r)	4	Westminster		<i>Jea</i> th		Carroll	Jeani	
Funeral		· · · · · · · · · · · · · · · · · · ·	ge (In yrs. last b	oirthday)	If Under 1 Year	If Under 2		Date of Birth	(MM/DD/YYYY)	9. Birthp	lace (State or
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Aaryland 28a-f show	Director	10e. Street and Number			10f. Zip Code			100	g. Citizen of What		1?
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th with	eral	11. Marital Status 1 Never Married 2 Married Armed Forces			Decedent of Hisp es, specify Cuban,				14. Race - A White, 6		n Indian, Black,
er dea	Fune	3 Widowed 4 Divorced If Yes, Give Year V	≧∏ № ietnam	1	Yes 2 No	specify:			Specify:	wh	nite
ours aff	p	15. Decedent's Education (Specify only highest grade co		a. Decedent	's Usual Occupation	on (Give kin		done	16b. Kind of Busin		ustry
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than the event, the Medical	Ē.	17. Father's Name (First, Middle, Last)			- 1	8.Mother's N	Name (Fir	st, Middle, Ma	aiden Surname)		
215. e filed stal Hy ked of	Bec	Lloyd M. Deal				Ruth	Mari	e Shaq	gogue		
D 21 hould I nd Mer is man		19a. Informant's Name/Relationship (Type, Print)			Address (Street Old Tar						
MD and 2 sho salth and em 27 is	-	Diane R. Deal, wife	20b, Plac		tion (Name of cerr		Da		20c. Location - C		
IOFE iges 1 : it of H. it: If it		1 Burial 2 Cremation 3 Removal from S	tate Arem	bo√aid remato	e rma ce)		10/6	/2011	Manche	ster	c, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatie event, the Medical Examiner must be notified at once	ŀ	4 Donation 5 Other Specify: 21, Signature of Funeral Service Licensee			ame and Address Willis				boraw Fu	nera	al Home
E L Pe C		Justi R. Dubora	2								
Physician Medical		23a. Part I. Enter the disease, or complications that cause failure, List only one cause on each line.	d the death. Do	not enter th	e mode of dying, s	such as card	liac or res	piratory arres	st, snock, or neart		Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a Head Injuries Due to (or as a con	sequence of):							-	
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Box 68760, e death certificate b the attending physical for use as the bu	cian	23b. Was decedent pregnant in the past 12 months?	at time of death	- =	aldeath ³ L ner (Specify)	Ectopic p	regnancy		Month	Day	y Year
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Division of Vital Records, tal or Attending Physician: The law requirers after death. The Director: After this certificate has been so ted in by the funeral director, page 2 should be a base of the funeral director, page 2 should be a second to the funeral director.		25. Was case referred to medical			26. Place	of Death (C	heck only	1 Yes 2	No 1	Yes	2 No
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Division of Vital Records, P.O. Box 68760 To the Biospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu		29a, Certifier 1 Certifying Physician: To the best of	my knowledge,	death occur	ed at the time, da	te and place	e, and due	to the cause	(s) and manner a	s stated	
To the within To the compl	Medical	one) 2 Medical Examiner: On the basis of examiner states 29b. Signature and title of certifier	amination and/o	or investigat	29c, License		rred at the	time, date a	29d. Date signed		
	2		SVI		O.C.M				October 4, 2	·	,, <i>Day</i> , , dar,
-10	ŀ	30. Name and address of person who completed cause of	death (Item 23a	a)							
JA 10	_	Melissa Brassell, MD Assistant Medica	al Examiner		. Baltimore St	reet, Bal	timore,	MD 2122	3		
Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Regist	rar's Signature	bo	West						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death (72) Physician/ Month 2011 11:25A M Charles Edgar Dukehart, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Carroll Lutheran Village Healthcare 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) 6. Sex Country) MD Funeral Days Hours 1 X M 2 □ F Months 0771171922 710-09-7393 89 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland Director Yes 2 No Westminster MD Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21157 219 Uniontown Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?

1 X Yes 2 \(\subseteq \text{No.1942-} \) Black, White, etc. <u>م</u> 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced Completed 1945 other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Balt-Ohio Chessie Sys. railroad Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Page 1 and 2 should be Sybil Dorsey Charles Edgar Dukehart, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 219 Uniontown Road, Westminster, MD Katherine Dukehart/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. 7, 2011 Westminster, MD 4 Donation 5 Other (Specify) John Cemetery Pritts Funeral Home & Chapel 21, Signature of Funeral Service Licens 22. Name and Address of Facility 21157 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an nas autopsy this certificate 1 Yes 2 No To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1. Natural work 5 Pending 1 Tes 2 No Investigation 6 Could not be 2 Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 401 1005170 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Westminster MD 21167 Malcolm Pansuriya Macyan J-31. Date filed (Manth, Day, Year) distrar's Signature State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOMAS KE GALVININ

OCT 0 6 2011

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 10 2011 Physician/ 63 12:00 PM Harold Vincent Desmond, Jr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Westminster 643 Hook Road 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 🌠 M 2 🗆 F 40717/1932 NY 78 Director 067-26-2105 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 ☐ Yes 2 🕅 No Westminster MD Carroll 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 21157 USA 643 Hook Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No. 1 Yes, Give Year or Dates. Black, White, etc þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: Korea Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Insurance Co. Auditor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Emeline Devlin Harold Vincent Desmond, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 643 Hook Road, Westminster, MD Mary C. Desmond - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Mem. Garden 10/07/2011 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA ul 21157 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2CeAudisease or condition resulting in death) Medical Examiner Sequentially list nonditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Day ate has been signed by the atte page 2 should be detached for 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has Be 25. Was case referred to predica 26. Place of Death (Check only one) funeral director, Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 은 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Matural 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide Investigation after death the 6 Could not be To the Hospital or Atter within 24 hours after de To the Funeral Director completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Dav. Year, Jalus in WJL ~om coo 10+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IVA ILTOMAS K. GAWN STONER AVENUE Westmin ster MALLylin in ma 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2011 Year Physician/ Sadie Mae Dukes October 1:45 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2798 Quantim Court Manchester Carroll 6. Sex Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 215-28-7624 1 M 2 X F Months Days Hours Min (Month, Day, Year) 78 **Director** 19 1932 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City. Town or Location event, the Medical Examiner must be notified at Director Maryland Carroll Westminster 1 ☐ Yes 2X No 10e. Street and Number 10f, Zip Code 23a or 10g. Citizen of What Country? Funeral 475 Summit View Drive 21158 United States or items permit. Page 1 and 2 should be filed within 72 hours after death of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) certified nurse assistant nursing home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sadie Mae Pauley Willy Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Faye Dockins / daughter 475 Summit View Drive Westminster, Maryland 21158 Date 7, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State oct. 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other Arbutus Mem. Park Baltimore, Maryland 2011 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service License Hampstead, Maryland 21074 934 South Main Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ FAILURE HEART disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner YEARS FAMILIAL AMYLDIDOSI Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to lor as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Dav Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has funeral director, page 2 s autopsy 1 \(\text{Yes} Yes 2 X No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🏋 No æ 26. Place of Death (Check only one) daughter's Other: 4 \square Nursing Home 5 \square Residence 6X Other (Sp Hospital: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural injury s after dea... ral Director: Aft/ "Ny the fi 5 Pending Accident Suicide Investigation 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medica Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of ce 29d. Date signed (Month, Day, Year)

Registrar

State

WIL

600 North Wolfe Street

DOCTOR OF MEDICINE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ryan Tedford, M.D.

31. Date filed (Month, Day, Year)

66269

OCTOBER 3.

Baltimore, Maryland 21287

2011

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 5, 2011° October 1:30a M Sorin Damian Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick 8203 Winter Snow Court Frederick Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday, Days Hours Director 623-72-4946 1 🖾 M 2 🗆 F 58 April 28,1953 Romania Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits эегтіt. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 8203 Winter Snow Court United States ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, , o. 1 Yes 2 No þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: White Year or Dates ed other than "natur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. 5+ Bio Technology Research Scientist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental Hitem 27 is marked of other traumatic even ပ္ Dumitru Damian Steluta Topolinski 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8203 Winter Snow Court, Frederick, Maryland 21702 Department of Health Important: If item 27 any injury or other th Zoe Damian / Wife 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 🛭 Cremation 3 🗆 Removal from State Stauffer Crematory Inc. 10/7/11 4 Donation 5 Other (Specify) Frederick, Maryland. 21. Signatur Juneral Service License Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between CARDIOVASCULAR Disense 1TheroscleroTIL Immediate Cause (Final Onset and Death Physician/ yenns disease or condition / Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li Fetal doc.
Pregnant at time of death
Unknown 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year signed by the at Id be detached for 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dinberes Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of has autopsy performe death? After this certificate 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 卢 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. 2 Accident
3 Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10-5-11 MO 10035152 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNSON DO. Frederick, MD 21702

Registrar DHMH 17 Rev 06-2011

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State

31. Date filed (Mo

Thos

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Registrar's Signature

MD

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		Ame	ended Item 1 Please Type or Pri State of Ma	nt in Black Indelible 2011 Carroll Cou aryland / Department of	Ink. Ensure All nty, will of Health and Me	Copies Are	Legible.	
		1	For State Registrar	Certificate of		Reg. No		3374/
			Decedent's Name (First, Middle, Last)			. Date of Death		3. Time of Death
н	Physicia Medic		CHARLES & EVELAND, J.C.	CHARLES B. EV	ELAND, JR. S		20 2011	6:23 P M
granted.	Examin	er	4a. Facility Name (if not institution, give street and number) FREDERICK MEMORIAL H		n, or Location of Death		County of Death	X
5	Funeral Director		5. Social Security Number 204-34-4842 6. Sex 1 ★ 2 □ F 7. Age	67 Yrs. In the light of the lig		Date of Birth (Month, Day Year)	a Coun	blace (State or Foreign try) Ms bus 5, PIA
	yland -f show ed at	It	Usual Residence of Decedent 10a. State 10b. County 10c C	10c. City, Town or Location Hanover, P	Α		1	0d. Inside City Limits 1 ☐ Yes 2 📉 No
	h the Mar 3a or 28a be notifi	al Director	10e. Street and Number 560 Fuhrman Mill	10f Zip Co		10g. Ci	itizen of What Cour	
920	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	4 1	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	ever in U.S. 13. Was Decedent	of Hispanic Origin? (Specifi Cuban, Mexican, Puerto Ric	y Yes or No- ean, etc.)	14. Race - Americ Black, White,	
21215-0036	ithin 72 hours ene. • than "natur the Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5	16a. Decedent's Usual O (Give kind of work d	one during most of working ired)	111	Find of Business In	
	uld be filed within Mental Hygiene. Narked other tha	To Be	17. Father's Name (First, Middle, Last) Charles Benjamin E		18. Mother's Name (F	First, Middle, Maiden	4	
Maryland	and 2 should Health and Me tem 27 is mar ther traumati		19a. Informant's Name/Relationship (Type, Print) Patricia A. Eueland	19b. Mailing Address (Si	reet and Number or Rural R	oute Number, City or	r Town, State, Zip (
Baltimore,	a. 0 4- 1-		20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposition (Name of	of Det	e 20c I	ocation - City or To	own, State
Balti	permit. Page Department Important: I any injury o		21. Signatur Funeral Strvice Lice (see	22 Name and A	ddress of Facility We	TOL MILLAN.	esal House	ue and over, () 17351
-	Physician/		23a, Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition			espiratory arrest,		Approximate Interval Between Diset and Death
Name of	Medical Examiner		resulting in death) Due to (or as a Light of the control of the c		inoma			lyean
	uted d ansit	Examiner	Scientificity is a notificate if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	a consequence of):				
90	te be executed nysician and ne burial-transi	- 1	resulting in death) Last Due to (or as death)	a consequence of):				
Box 68760	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	2 Fetal death 3 Ectopic pre-			23d. Date of deliv Month	rery Day Year
, P.O.	requires that the de been signed by the should be detached	d by Ph	Part II. Other significant conditions contributing to death be	out not resulting in the underlying cau	se given in Part I.		use contribute to t	he cause of death?
ecords	rsician: The law requii s certificate has been lirector, page 2 should	mplete				24a. Was an autopsy performed?	prior to co	psy findings available ompletion of cause of
Ä	n: The fficate or, pag	ပိ	25. Was case referred to medical		26. Place of Death (Check o		No 1 Yes	2 L No
Vita	ysicia s cert directa	To Be	examiner?	ent 2 ER/Outpatient 3 DOA	Othor	e 5 Residence	6 ☐ Other (Specif	y)
of	ng Phy ter thi neral		27. Manner of Death 1 X Natural 5 ☐ Pending (Month, Da	ry 28b. Time of 28c.		d. Describe how inju		
Division of Vital Records,	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Certificate:	2 Accident Investigation	ury - At home, farm, street, factory, o c. (Specify)	1 🗆 Yes 2 🗆 No	Rf. Location (Street ar City or Town, State		I Route Number,
Δ	To the Hospital within 24 hours a To the Funeral I completed filled	Medical	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of e only one) 3 Certifying Nurse Practioner: To the	xamination and/or investigation, in my	opinion, death occurred at th	e time, date and plac	e, and due to the ca	ause(s) and manner stated.
	WITE	2	29b. Signature and title of certifier Marity - Min Neflin 1	29c. L	cense number D72977		ate signed (Month,	
	iativa		30. Name and address of person who completed cause of d		thst. Fred	· · · · · · · · · · · · · · · · · · ·	1 2171	
	- Ct-		Masius Julian Neflig 31. Date filed (Month, Day, Year) 32. Belistr	400 W.7	Jr. LLGG	ewell (in	7 2/10	(
	Sta Registra		SEP 2 9 2011	A base				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 11:25 PM Betty Lee Fox Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8634 North Bali Court Ellicott City Howard Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday, **Funeral** Months 219-22-3163 **Director** 1 🗆 M 2 🔀 9-29-1928 MD 83 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Ellicott City 1 🗆 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8634 North Bali Court 21043 United States and 2 should be filed within 72 hours after death w Health and Mental Hygiene. tem 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Was Deces? Armed Forces? Race - American Indian Black, White, etc. 1 🗆 Never Married 2 🗆 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 🙎 🗆 No If Yes Give 3 Widowed 4 □ Divorced Specify: Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Banking Manager Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Arthur L. Woods Sr. Edna L. Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry E. Fox III/Son 2404 Stoneyside Drive Fallston, MD 21047 permit. Page 1 and 2 Department of Healt Important: If item 2; any injury or other t 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Ellicott City, Md. Good Shepherd Cem. 10-12-11 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Coll 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 22 disease or condition y ears Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 as the l IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day 5 Other (specify) ed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No ours after death. eral Director. After this certifica filled in by the funeral director, 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 MDResidence 6 Other (Specify) 1 Yes 2 PNo ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral L Medical 29a. Certifier 1 E-certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier 038762 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
54// 8/d Frederick 2d TSuite Mc Cornack Baltime, N Sharon 10 21229 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Ellon. Garrison 2011 Andrea Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Laurel Regional Hospital Laure Prince George Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday, **Funeral** Days 1 M 2 X Months Hours Min 1949 North Carolina 241-72-9107 61 December 12. **Director** Usual Residence of Decedent 28a-f shov 10a. State 10d. Inside City Limits aţ 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified 1 🗌 Yes 2 🗓 No Maryland Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 15615 Dorset Rd., T-3 20707 death v 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 X No "natural", or 1 X Never Married 2 Married Completed by 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: 3 Divorced 4 Divorced White Year or Dates other traumatic event, the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) Experience Works Payroll Specialist Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ပ Mary Ellon Echols Hestel E. Garrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Sherin Drive, Newark, Delaware 19702 Thomas Garrison—Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland Oct. 6, 2011 Atlantic Crematory 21. Signature of Fundra Service Licensee 22. Name and Address of Facility
Fleck Funeral Home, Inc. M0123 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Infarction .Ph_sician/ disease or condition resulting in death) Myocardia Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any leading to in rectall cause. Enter Underlying Examine Due to for as a consequence of: sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of) ending physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atten for u in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 욘 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 XDOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 X Natural 5 Pending work 1 Yes 2 🗌 No Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Under the cause of (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D56433 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen Rd. Sendi, MD Christopher Regional Hospital, Emergency Laurel 31. Date filed (Mor strar's Signature State 0 5 201 Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		State Registrar	1.11. 1.004)			Cer	tificate	of Dea	ath			Reg. N	011		337	
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Funeral Director		5. Social Security Number	6. Sex	м 2 Х F	7. Age (In yrs. 82	last birthday) Yrs.	If Under 1 Months		<u>Under 24 H</u> lours Mi	in. (/	Date of Birt Month, Day	v. Year)		Country	ce (State or v)	r Foreign
		220-34-2280 Usual Residence of Decedent								130	1y 17	7, 19	291			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inpertment of Health and Mental Hygiene. In Hygiene 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director		^{inty} ashing	ton		ity, Town or Loc onsboro	cation							10	d. Inside Cit	•
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artmer artmer ortant injury		4 Donation 5 Oth		1 0	Bo	onsbor	O Ceme				2011				<u>Maryl</u> . Home	
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Medical Examiner		disease or condition resulting in death)	C a.	Due to	(or as a consec	quence of):	1		- 7		, -0 ,	4 - 00	-		O/V	००० व
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within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medic	al Examiner	: On the bas	est of my knov sis of examination To the best of m	on and/or invest	igation, in my	opinion, d	eath occurre	ed at the ti	me, date a	nd place, a	and due to t	he caus	e(s) and mar	nner stated.
within To the Comp		29b. Signature and title of cert		1				icense nur					signed (Mo			
		flden	e l'	10.	-) pm	<i>></i>	4	236	525		(Jita	she	11	, 20	11
17		30. Name and address of pers	on who com	pleted care	se of death (Iter	n 23a) (Type, P	rint)	oh	ned	لعضا	Co	wo.	22	12	<u>k</u>	
Stat Registra	-	31. Date filed (Month, Day, Yea	2011	32 R	ėgistrar's Signa	ature	W			- 1	Take	114	Nur		m	\$

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			State of Maryland / Department 1 - State Registrar Certificate	t of Health an e of Death		2011	33751
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Grant Spiher Haines		October		4:17 P M
7	Examin		Tall y deline (in the internal of great and in ernal of great and internal of great and in the internal of great and internal of great and internal of great and internal of great and internal of great and grea	Town, or Location of D		4c. County of Deat	
				gerstown 1 Year If Under 24	Hrs. 9 Date of Birth	Washington	n County
	Funeral Director		5. Social Security Number 225-05-0980 6. Sex 12 F 95 Yrs. 6. Sex Months		Min. 8. Date of Birth (Month, Day, 1) Feb. 6,1	916 Pen	hplace (State or Foreign untry) nsylvania
	2		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	show	5					1X Yes 2 □ No
	the M	Director	Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip	Code	10	g. Citizen of What Co	ountry?
	with			742		U.S.A.	
	ns 23	Funeral	12 Was Decedent Ever in U.S. 13 Was Decedent	Hent of Hispanic Origin	? (Specify Yes or No-	14. Race - Ame	
36	irs after o	by Fur	Amed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced Amed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, Give 1943— 1 Yes 1 Yes 1 Yes, Give 1943— 1 Yes	cify Cuban, Mexican, P 2 X No Specify:	ruento rican, etc.)	Black, White	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. If The Strand Str	Completed	15. Decedent's Education 16a. Decedent's Usua	al Occupation ork done during most of		6b. Kind of Business	/Industry
21		nple	Flementary/Secondary (0-12) College (1-4or 5+)	se retired)		Aircraft	M£~
2		To Be Cor	17. Father's Name (First, Middle, Last)		Name (First, Middle, M		MIG.
Maryland			Vernon Haines				
2			Vernon Haines Freda Spiher Haines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				Zip Code)
	12 mg		Doris M. Haines-wife 163 Sunbro	ook Lane H	a erstown,	MD 21742	
Je,	s 1 and 2 of Health item 27 other tre		20a. Method of Disposition 20b. Place of Disposition (Nar cametery, crematory or c	me of other place)	Date 2	0c. Location - City or	Town, State
Ē	Pages nent of nnt: If it iry or o		1 □ Burial 2 M Cremation 3 □ Hemoval from State 4 □ Donation 5 □ Other (Specify) Smithsburg Cre	ematory 1			
Baltimore,	permit. Pages Department of Importent: If it any injury or of once.				Douglas A. vd. North H		
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)			Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				
			Sequentially list conditions b. MYO CARDIAL INFARLTION			3 DAYS.	
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8760,		by Physician/Medical					YEMU.
Vital Records, P.O. Box 6			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic p 4 Pregnant at time of death 5 Other (sp			23d. Date of de Month	olivery Day Year
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			se. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably → ☐ Unknown	
		Completed			24a. Was ar autops perform 1 \subseteq Yes 2	prior to	utopsy findings available completion of cause of
		Be C	25. Was case referred to medical 26. Place of Death (Check only one)				
of V	> 9 0	To	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ Do		ne 5 Residence 6 Other (Specify)		
0	ding Pl	on:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		8d. Describe how injury occurred		
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Division		Certification:	4 Homicide determined determined building, etc. (Specify)	and 286. Place of injury - At nome, farm, street, factory, office		sity or Town, State)	
		Medical (29a. Certifier (Check only one) 1// Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	To th within To th compl	Me	29b. Signature and title of centifier 29	c. License number	29	d. Date signed (Mor	nth, Day, Year)
	1		> Dedu mo	046561		Oct 10.	2011
	13X1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GIA ZALA QADIR 1(90 Mr ABWA ROAD (HAGENTOWN MI) 21740.				
		State Registrar 0CT 1 2011 32. Fegistrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Timothy Hull a. 4:05 PM OCTOBER 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death University of Manyland tredical Baltmore Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) May 21, 1 X M 2 🗆 Days Hours Maryland Director 219-88-6824 36 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he material once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No WV Great Cacapon Morgan 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6928 Cacapon Road 25422 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 X Married þ 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ing Elementary/Seconday (0-12) College (1-4 or 5+) Heating & Air Condition 11 Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Dennis Michael Hull Sandra Kay Lapole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Dunsworth/Sister 21783 10 Orndorff Dr., Smithsburg, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 \square Burial 2 X Cremation 3 \square Removal from State 10/10/2011 Smithsburg, MD Smithsburg Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one of at of s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician Cirrhosis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hepanhs Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Within 24 hours after death.

The Funeral Director After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Alcohol Abuse 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 X No 1 🗌 Yes 1 Unpatient 2 ER/Outpatient 3 DOA ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide (Month, Day, Year) 5 Pending injury 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) ender & walker, LO 1588963946 OCTOBER 7 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 225. Greenest Bulmuz, Mp 21201 Walker, MD Werdy

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Evelyn Herrington Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington . Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕅 F Days Months July 10, Hours Year) 932 210-24-7691 Director 79 Pennsylvania Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits **Funeral Director** or 28a-f 1X Yes 2 ☐ No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe 23a 300 Northern Ave.Apt. 4C must 21742 U.S.A. , or items Page 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner mury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give White Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Spiraller Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Cleo R. Royer Agnes E. Pyles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard R. Herrington/Husband 300 Northern Ave. Apt.4C, Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 at Department of H Important: If itel any injury or oth Date 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rest Haven Cemetery 10/11/2011 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death crebral Ph. sician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner NEJMON! Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Per cm 5,0 u burial-tran that initiated events resulting in death) Last Due to (or as a consequence of attending physician I for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗹 No မ Inpatient 2 🗆 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number DO 60396 10/10/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 90

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31. Date filed (Mor

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 33754 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1747PM Lisa Marie Harrell 10 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2XX Months Days Hours Min. Juneth, 7°, 1′966 ^cMaryland Director 233-21-7336 45 Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Completed by Funeral USA 18043 Mason Dixon Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working d Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Accountant</u> Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Phyllis Ruth injury or other traumatic Ronnie Glen Stanley Rayner 1 and 2 should by Health and Meittem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21740 James E.L. Harrell - Husband 18043 Mason Dixon Road Hagerstown, Maryland 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park |Oct.12,2011|Hagerstown,Maryland en Funeral Serves Lies Osbornead Hanerally Home, P.A. 425 S. Conococheague St.Williamsport, MD 21795 Inter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsi disease or condition Medical resulting in death) Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, ce to ac Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After Natural 5 Pending iniury thin 24 hours after death, the Funeral Director: After mpleted filled in by the fun 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and tifle of certifier 29c. License number 29d. Date signed (Month. Day, Year) Oct ber 8 P065445

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month Day

Jetterson

gistrar's Signature

150 v

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22911

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8-17PM Physician/ OCTOBER JEAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Glen Burnie Baltimore Washington Nedical Conter 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** Country) JEST VIRBINIA (Month, Day, **Director** Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Funeral Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates 3 ₩idowed 4 Divorced Completed かても 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) VEDENCE CONTRACTION Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21127 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-19-11 GENB Signatore Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List any one cause on each line. arrest Approximate cause on each line. Interval Between Onset and Death Immediate Cause (Final anchi 77 Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Completed by Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or iinjury the burial-trans been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes To the Hospital or Attending Physician: The law requir within 24 hours atter death.

To the Funeral Director: After this certificate has been a 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

1 Yes 2 No death?
1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, examiner? Hospital: Yes Certificate: To 1 plinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatui 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) Name and address of State Registrar

11-07757	Please Ty	pe or Print in	Black Inc	delible l	nk. Ensure	e All Copi	ies Are L	egible.		
Emily Cotter Hauze	S	tate of Maryla	nd / Depai	rtment o	f Health and			201	1 33756	
	1- For State Registrar		Cert	fificate of	f Death			Reg. No.	1 33130	
Physician/ Medical Examiner	1. Decedent's Name (First, Midd Emily Cotter						2. Date of D Month October	eath Day Year 16, 2011	3. Time of Death 0830 hrs	
and and	4a. Facility Name (if not instituti 218 N. Charles Stree		mber)		4b. City, Town, or I Baltimore	City, Town, or Location of Death 4c. County of Death altimore				
Funeral	5. Social Security Number	6. Sex	7. Age (in yrs. la	st birthday)	If Under 1 Year	If Under 24H	rs. 8. Date of	8irth(MM/DD/YYYY)	9. Birthplace (State or Foreign	
Director	177–72–1143 Usual Residence of Decedent	1 M 2 X F	23	Yrs	Months Days	Hours M	in. 03/0	1/1988	Country) PA	
any	10a. State 10b. County			Town or Local					10d. Inside City Limits	
and show	PA Chest	cer	Pho	enixvi	lle				1 Yes 2 X No	
the Maryland a or 28a-f show any tified at once. Director	10e. Street and Number 3004 Doris Ct.				10f. Zip Code 19460		_	10g. Citizen of Wha	t Country?	
death with the ritems 23a	11. Marital Status	A 1 = .	edent Ever in U.S		as Decedent of His				American Indian, Black,	
s after death rral", or ite niner must by Fund		Married Armed For 1 Yes vorced If Yes, Give Year or Dates:	2 X No		es, specify Cuban,		to Rican, etc.)	White,	White	
hours fixami	15. Decedent's Education (Spe	ecify only highest grade			nt's Usual Occupati ost of working life.			16b. Kind of 8usi	ness/Industry	
5-0036 led within 72 hour object than "natu the Medical Exar Completed	Elementary/Secondary (0-12)	4	4 or 5+)		cher			Educati	Lon	
215- be filed nital Hy rked of rent, the	17. Father's Name (First, Middle Charles G. Hau	ize				Ellen (Cotter	e, Maiden Surname)		
MD 21 of 2 should alth and Me m 27 is ma aumatic ev	19a. Informant's Name/Relations Brett Hauze /			218 A	delphi St	t., #2,		umber, City or Town, yn, NY 112	205	
Baltimore, MC bemit Pages I and 2 sl Department of Health at important: If item 27	20a. Method of Disposition 1 8urial 2 X Cremation		m State Cr	ematory or ot	ition (Name of cent her place) 1 Cremat o	140	Date /20/201	20c. Location - 0 1 Odenton,	ity or Town, State	
Baltimo permit. Pag Department Important: injury or of	4 Donation 5 Other S 21. Signature of Funeral Service		M01452	22. N Ba:	ame and Address	of Facility eral Hon	ne and (Cremation	Service, PA	
Physician	23a. Part I. Enter the disease, or		used the death I					thorpe, MD arrest, shock, or hear	Approximate Interval	
/Medical Examiner	failure, List only one cause Immediate Cause (Final disease		e Injuri	Les					Between Onset and Death	
<u>L</u> Adiminei	or condition resulting in death)		consequence of)							
	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of)							
red nsit Examiner	cause Enter Underlying Cause			80				500		
ed nsit	events resulting in death) Last	Due to (or as a d	consequence of)							
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). Box 68760, the death certificate be except by the attending physician ched for use as the burial Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in t		utcome of pregna	-	tal death 3	Ectopic pregi	nancy	23d. Date of do	elivery Day Year	
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Bo ne dear the ar	1 Yes 2 No 9 V Un	9 Unknov								
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R cords, The lay requires ficate has been sign, page 2 should be								topsy pri	or to completion of cause of ath?	
tal Ruc tian: Tiel certificate I ector, page	05.11/						1 🗸 Yes		Yes 2 No	
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1 of V Jing Phys After thii funeral di	1 ✓ Yes 2 No 27. Manner of Death	28a. Date o	f Injury	28b. Time of I		y at Work?		e how injury occurred		
sion of tendin death. ctor: A y the fur	1 Natural 5 Pend	ding Fd 10	Day, Year) 0-16-11	fd 08:0	4 am 1 Y	es 2 X No	Fall d	lown trash	chute	
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To the How within 24 h completely completely	141144	hysician: To the best miner: On the basis of	_							
within 12 to the Fit completed	29b. Signature and title of certifie	and manner sta			29c. License			· · <u>· · · · · · · · · · · · · · · · · </u>	(Month, Day, Year)	
	Caroli	Halla	U		O.C.N			October 17,		
61	30. Name and address of person Carol Allan, MD As	who completed cause sistant Medical E			timore Street,	Baltimore, N	MD 21223			

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day, Year) OCT 2 4 2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Plea Foramend# 5 per F state 10/17/2011	ase Type or I H State of				k. Ensure <i>I</i> Health and N			egible.	33757
		State 10/17/2011 Registrar 1. Decedent's Name (First, Middle		EPT. CM	I Cen	tificate of l	Death	2. Date of De	Reg. No.		3. Time of Death
Physicia Medic		Clara	Belle		ones			Septemb	er 30, 2		7:18 A M
Examir	ner	4a. Facility Name (if not institution Patuxent River Nur			r	4b. City, Town, o			inty of Deat ince Ge		
Funeral Director		5. Social Security Number 242-32-63-44	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. la 82	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir May 29,	1929		thplace (State or Foreign ntn Carolina
show d at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loc	ation				10d. Inside City Limits		
or 28a-f notifie	Funeral Director	Maryland Howar	<u>d</u>	Ellic	cott Cit	y 10f. Zip Code			10g. Citizen	of What Co	1 Yes 2 No
s 23a c	neral	4922 Clearwater D	rive			21043			USA		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 Never Married 2 Mar	If Yes, Give	ces? 2 X No	 13. Was Decedent of Hispanic Origin? (Specify Yes or Note of the Information of					Black, Whit	rican Indian, e, etc. √hit e
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d 2 should alth and N 1 27 is ma er trauma		19a. Informant's Name/Relations Arthur H. Jones,			19b. Mailin 4922 C	g Address (Street learwater	and Number or Rur Drive, Elli	al Route Number	er, City or Town y, Maryli	n, State, Zi and 210	043
Page 1 an nent of He int: If iten iry or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (8		State C	emetery, crem	sition (Name of natory or other pla Cemetery	ce)	Date 6, 2011			Town, State Maryland
permit. I Departra Importa any inju		21. Signature of Funeral Service	Licensee 00	1234	² F 7	Teck Funer 601 Sandy	al folle, IN Spring Road	C. I, Laurel,	, Maryla	nd 2070	07
		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on eac	h line.				or respiratory ar	rest,		Approximate Interval Between Over and Death
Physician/ Medical Examiner		disease or condition resulting in death)	a	r or ova		th metastas	SIS				Over 1 year
d sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to (c	or as a consequ	uence of):						
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ficate b g physic as the b	Aedic		d								
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 【XNo 9 ☐ Unknown	1 ☐ Live E 4 ☐ Pregn	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month							olivery Day Year
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nding Ph tth. : After thi e funeral		27. Manner of Death 1 X Natural 5 Pendi 2 Accident Invest	28a. Date of (Monti	of injury h, Day, Year)	28b. Time of injury	wor	ry at k? ☑ Yes 2 ☐ No	28d. Describe	how injury oc	curred	
Il or Atter after des Director d in by the	Certificate:	3 Suicide 6 Could 4 Homicide deterr	not be 28e. Place	of Injury - At ho g, etc. (Specif)		eet, factory, office		28f. Location (City or To		ımber or Rı	ural Route Number,
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To the within To the comp		29b. Signature and title of contified	The state of the s	de	M.	29c. Licens D 247			29d. Date sig	gned (Monsober 3	
1.0		30. Name and address of person					0. 11	M1	20709		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 25 per me, g922, 12/05/2011 dnb

Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 02 2011 ntoinett 10 Medical 4a. Facility Name (if not institution, give 4c. County of Death **Examiner** Baltima e Social Security N be If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Haiti 1 ☐ M 2 🛣 F Months Hours 03-03-1952 595 06 1451 59 Yrs **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Nrundel Severn ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 1907 Hatboro Court 21144 Haiti Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 XDivorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) unknown Caterer Catering Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Absalon Jeudy Clara Destin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josiane Moise/Daughter 1907 Hatboro Court Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Cemetery of Gonaizes 10-15-2011 Gonaizes, Artibonite . Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner as been signed by the attending physician and 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last CERTIFICA IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 1 Yes 2 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ten510~ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed the funeral director, page 1 Yes 2 No Be B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗌 No Other: ပ 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Box 68760 Records, P.O. Vital Division of

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Registrar

Medical

29a Certifier

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orly on 29b. Signa

31. Date filed (Month, Day, State

Greene

Medical Examiner: On the basis of examination and on involving Murial Practionars To the best of my knowledge, seeth occurs

Knun

LEWIS, MD. 120 Baltimon MD 21201

Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Number Franklehmer to the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Number Franklehmer to the basis of my knowledge death occurred at the time, date and place and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

30. Name and address ss of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3759 Time of Death 15 p M (State or Foreign a Inside City Limits 1 Yes 2 No of the control of the contr
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33760 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Physician/ 20% David Wayne KEYTON 0511 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) eb. 6, 1963 1**X** M 2 □ F Months Days Hours 48 Maryland Director 212-88-9772 Usual Residence of Decedent 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a.f show 10a. State 10c. City. Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Washington Sharpsburg 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 21782 USA 4529 Harpers Ferry Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white Specify: 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12 farming farmer/laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ June Caroline Griffith Lester Stanley Keyton 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Bedrock Ln., Keedysville, Md. 21756 1 and 2 s June C. Wyand - mother injury or other 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it. 5 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10/12/11 Sharpsburg, Md. View Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Lige 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final gastro-intestinal bleedu Physician/ ewelk disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of physician and the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown been signed by the a should be detached 9 Linknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ taline. Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; I of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work?
1 ☐ Yes 2 ☐ No Division Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) D44996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2031/Coffans ld Boonson MD 2/7/3 7W-Z 32. Pegistrar's Signature State OCT 12 2011

Registrar

Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

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		negistrar Decedent's Name	e (First, Middle,	Last)			11110010 07 2			2. Date of Dea		<u> </u>	-	3. Time of Death		
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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na ARTHENIA			SHTER		ng Address (Street a				-		tate, <i>Zip</i>			
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within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b.	Medical	(Check 2	☐ Medical Ex	aminer: On the b	asis of examinatio	n and/or inves		n, death o	ccurred a	t the time, date an	nd plac	e, and du	e to the c	ause(s) and manner stated.		
within 2 Го the сотрlе		only one) 3 29b. Signature and		Nurse Practition	er: To the best of r	my knowledge	, death occurred at the 29c. License		ate and pla					s stated. , Day, Year)		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 8, 2011 6:50 P M October Louise Claudine Lochary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Homewood Retirement Center Williamsport 8. Date of Birth (Month, Day, Y March 5, Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Voor Hours 1 □ M 2 🗓 F Months Davs 1929 Maryland 82 Director 033-24-5563 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County ral", or items 23a or 28a-f show Examirer must be notified at 1 ☐ Yes 2 No Directo Maryland Washington Williamsport 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with LISA 21795 16505 Virginia Avenue Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 1 No If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. Pages 1 and 2 should be filed within 72 hours after on nent of Health and Mental Hygiene. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify: 2 3 ☐ Widowed 4 ☐ Divorced White "natural" Completed 27 is marked other than "nature traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) al Hygiene. Elementary/Secondary (0-12) Medical/Hospital 12 4 Industrial Therapist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olszewski Louise Lubarski ၉ Steve 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 16505 Virginia Avenue Cottage 64 Williamsport, MD Donald D. Lochary other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) o ii 6 permit. Page Department of Important: If any Injury or once. Hagerstown Crematory Oct. 11,2011 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune a Service Licenses 22. Name and Address of Facility Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, MD 21795 hais o Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Inter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** LUSTRIDE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Vear 5 Other (specify) been signed by the a should be detached f □Yes 2 🖫 lo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not respiting in the underlying cause given in Part I. Division of Vital Records, <u>۾</u> 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar 29b. Signaty

THEN

29d. Date signed (Month, Day, Year)

and manner stated.

Registrar's Signatur

32.

f certifier

1 - State Registrar 33763 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9/29/2011 Hartwell Melvin 9:15 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Westminster Carroll 4345 Salem Bottom Rd. If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 9/19/1941 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours Min. 213-42-8915 70 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evant is a mutth of an anone. 1 □Yes 2 XNo Funeral Director MD Carrol1 Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4345 Salem Bottom Rd. 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes _ 2 \overline{\Overline{\Omega}} No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify \$ Specify: 3 Widowed 4X Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hartwell William Melvin, Jr. Alice Louise Clark ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy Moore/Sister 4345 Salem Bottom Rd., Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【I Cremation 3 ☐ Removal from State Carroll Crematory 10/1/2011 4 ☐ Donation 5 ☐ Other (Specify) Winfield, MD 21. Signature of Funeral Service Ligensee Burrier Vueen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Parv. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** E CUID? Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician Physician/Medical in by the funeral director, page 2 should be detached for use as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occur 2 Medical Examiner: On the basis of examination and/or investigation and the basis of examination 9a. Certifier the time, date and place, and due to the cause(s) and manner as stated Medical in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number WIL m 23a) (Type, Print) 2 30. Name and address of person who completed 31. Date filed (Month, Day, Year) State Registrar

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Miller Physician/ Charles 201 07:18 AM Medical 4a. Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death 4b. City, Town Examiner Mary bund Medical Cer University of Baltimore 1 Year If Under 24 Hrs. If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min **X** M 2 □ F 212-38-4555 0971771940 MD 71 Director Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland at Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2000No Carroll Westminster MD 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21158 USA 530 Vision Way Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 No Specify: If Yes, Give 'natural", 3 Widowed 4 Divorced White Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) C.J. Miller, LLC 12 President event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever ၉ Clara Johanna Ernst Charles Jacob Miller, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 530 Vision Way Drive, Westminster, MD Katherine E. Miller/wife of Health 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Deurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 10/02/2011 | Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) Wesley Cemetery 21. Signature of Funeral Service 22. Name and Address of Facility Pritts Funeral Home and Chapel Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a coi Cause (Disease or linjury burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes Yes 2 No director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No after death. Accident
Suicide Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29d. Date signed (Month, Day, Year) hysician 2011 72512 WJL 35 s of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MO 21201 22 South Greene Steet QM, 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar 11-07410 Richard Metelski Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

chard Metelski		St 1- For State	ate of Mary		artment of			Menta	al Hy			distriction of	33765
Physicia		Registrar 1. Decedent's Name (First, Middl	e,Last)			- Journ			2	2. Date of Dea Month			3. Time of Death
edical Examir		Richard Metel								October 3	3, 2011		1322 hrs
)		4a. Facility Name (if not institution Frederick Memorial He		number)	41	o. City, To Frede r		ocation of	Death		4c. County of Frederic		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under	1 Year	If Under	24Hrs.	8. Date of B	irth(MM/DD/YYYY		
Director		139-72-8567	1 ^X M 2 F	44	Yrs.	Months	Days	Hours	Min.	June :	29, 1967	Cour	New Jersey
		Usual Residence of Decedent		140- 03-	Town or Location								10d. Inside City Limits
0 4 an		10a. State 10b. County Maryland Frede	rick		rederic								1 Yes 2 X No
Maryland 28a-f show any d at once.	Director	10e. Street and Number			Tedelic	10f. Zip (ode				10g. Citizen of Wh	at Count	ry?
the Ma	Dire	6707 Kings Mi	ill Court	:		2	1702	2			USA		
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	11. Marital Status		ecedent Ever in U. Forces?						cify Yes or N	o- 14. Race White		an Indian, Black,
or deatl	필	1 Never Married 2 X M. 3 Widowed 4 Div	arried 1 Yes	2 🔀 No		Yes 2				, ,	Specify:		white
urs afte	Š	15. Decedent's Education (Spe	or Dates:		16a. Decedent	s Usual O	ccupatio	n (Give ki			16b. Kind of Bu		
72 hou	etec	Elementary/Secondary (0-12)		(1-4 or 5+)	during mo Softwa:		-			ed)	Airn1an	o ma	nufacturing
within iene.	Completed		4			anage	r	-		Cient Middle	Maiden Surname)		
21215-0036 nuld be filed within 7 Mental Hygiene, marked other than c event, the Medica	Be C	17. Father's Name (First, Middle, Marion Metels)					10				kowski		
212 ould bould by I Ment	일	19a. Informant's Name/Relations	hip (Type, Print)	-	1.0						mber, City or Tow		
MD 2 sho alth and 2 sr is a mati		Judy Metelski 20a. Method of Disposition	i - wife	205	6707]				urt	, Fred	erick, Ma		
Ore,		1 Burial 2 Cremation	3 Removal	from State	crematory or other auffer	er place)			10-	10-201		•	, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other Sp 21. Sonature of Funeral Service		1 30		me and A					Funeral		
Ba perm Depa Imp	1	Maron (an	1000 C	line.							ederick,		
Physician		23a. Part I. Enter the disease, or failure. List only one cause		caused the death	. Do not enter the	e mode of	dying, si	uch as car	rdiac or	respiratory ar	rest, shock, or hea	art	Approximate Interval Between Onset and
Medical xaminer		Immediate Cause (Final disease or condition resulting in death)		sive Atherosci		vascula	ar Dise	ase				\rightarrow	Death
		Sequentially list conditions,	b	s a consequence o	,,								
	ine	if any, leading to immediate cause. Enter Underlying Cause		s a consequence o	of):								
d sit	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as	s a consequence o	of):								
ords, P.O. Box 68760, w requires that the death certificate be executed should be detached for use as the burial - transit	dical	UNPENDED	dAMENDE)							· · · · · ·		
60, te be e hysicia	Jedi	IF FEMALE:		s, outcome of preg	nancy						23d. Date of	delivery	
687 ertifica ding pl	jan/	23b. Was decedent pregnant in the past 12 months?	ne 1 Live	e birth gnant at time of de	2 Feta	al death	3 [Ectopic	pregnan	су	Month	Da	ay Year
Box 68760, e death certificate be the attending physicied for use as the burned	Physician/Me	1 Yes 2 No 9 Uni		known	eath 5 Oth	er (Speci	'y)						
P.O. Is that the gned by the detached	by Ph	Part II. Other significant condit	tions contributing	to death but not r	esulting in the ur	nderlying	ause giv	en in Parl	t I.				he cause of death?
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Of Vital Records ing Physician: The law requi After this certificate has been uneral director, page 2 should	Completed									auto	psy p		ompletion of cause of
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/ital ysician: nis certifi director,	Be	25. Was case referred to medica examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient						Residence 6	Other:	2112
n of Vita ding Physicia . After this ce funeral direct	n: To	27. Manner of Death	28a. Da	ate of Injury nth, Day,Year)	28b. Time of In	jury 28	Bc. Injury	at Work?	, ;	28d. Describe	how injury occurr	ed	
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Division of Vital Records, ppital of Attending Physician: The law required rest death and use after the series of the series of the series of the funeral director. After this certificate has been sifilted in by the funeral director, page 2 should be aftered to the funeral director, page 2 should be aftered to the funeral director.	Certification:	dete	Id not be 28e. Pi	ace of Injury - At h fv)	iome, farm, stree	, factory,	office bu	ilding, etc.		or Town,		ar or Kur	al Route Number, City
E E E 5		4 Homicide 29a. Certifier 1 Certifying P	hysician: To the t		lge, death occurr	ed at the	ime, date	e and plac	ce, and o	due to the cau	use(s) and manner	as state	d.
To the Howithin 24 h To the Fur	Medical	one) 2 Medical Exa	miner: On the bas and manne		and/or investigati				urred at	the time, date			
L > F 3	ž	29b. Signature and title of certific	er			29c.	License O.C.M				29d. Date sign. October 4,	•	th, Day, Year)
			uden nomentete 4)	(\$20)		U.U.IV	1.14.			October 4,	2011	
10		30. Name and address of person Russell Alexander MD		Medical Exar	1	N. Balti	more S	Street, E	3altime	ore, MD 2	1223		
	ate	31. Date filed (Month, Oay, Year)	7 201 1 32.	Registrar's Signat	ure la	Kal							
Regist	rar			4	1						OCA4T		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month October Day 5 Year Physician/ Miller 8.22 A M Reeves John 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford Birthplace (State or Foreign Country) If Under 5. Social Security Number 6. Sex If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Months Hours Min (Month, Day, Year) 82 Director North 242-40-0043 Carolina Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD Cecil Conowingo 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 135 Moore Road 21918 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes XXNo
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 🗙 o Specify: Spewhite 3 Widowed 4xxpivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Logging 10 years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0 Daul Miller Laura Effie (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Miller - son 513 W. 17th St., Elma, WA 98541 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🔲 Burial 2 🔀 emation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Evans Eagle Crematory 10/18/11 Leola, PA Signature of 22. Name and Address of Facility ober Harkins F.H.Inc.,Delta,PA 1<u>7314</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a conseque ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence for use as the burial-transit signed by the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant a 9 Unknown Pregnant at time of death Other (specify) Yes 1 ☐ Yes 2 L 9 ☐ Unknown completed filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 읻 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 \(\text{Yes} \quad 2 \(\text{No} \) 1 Natural 5 🔲 Pending 2 Accident
3 Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20063653 October 15, 2011

Registrar

State

South Union Krows Have de Gree, MD 21078

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Evons

24

Shawn EV
31. Date filed (Month, Day, Year)

501

State of Maryland / Department of Health and Mental Hygien ? For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2011 **Eshleman** Physician/ Martin Charles 9:06 A. Oct. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington 12635 Unger Rd Smithsburg If Under 1 Year | If Under 24 Hrs 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) Days Nov. 19, 1923 M 2 □ F Maryland Director 219-12-0298 87 Usual Residence of Decedent 28a-f show 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Washington Smithsburg Md. 1 🗌 Yes 2 🖵 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A 21783 12635 Unger Rd. death \ "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 72 hours after 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: 3 Divorced 4 Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fariner 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Farm Be 18. Mother's Name (First, Middle, Maiden Surname)
Amanda S. Eshleman 17. Father's Name (First, Middle, Last) Jacob A. Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12635 Unger Rd. Smithsburg, Md. 21783 19a. Informant's Name/Relationship (Type, Print) Susan H. Martin (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Oct. 20, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) stouffers-Pondsville Smithsburg, Md. 2011 Mennonite Cemetery
22. Name and Address of Facility Signature of Funeral Service Light 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Carcinory yo epithelial Ph_sician/ disease or condition resulting in death) 1149 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Denvntig 1 Yes 2 No 3 Probably 4 Unknown Completed Diabetel 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy Hypertansion performe 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 1 Residence 6 \(\text{Other} \) Other (Specify) 1 Tes 2 Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jefferson Bluf State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

f	_ State	aryland / Depa		lealth and Mental Hy	0	33768				
Physician/	Registrar 1. Decedent's Name (First, Middle, Last) Mary 1	Elizabeth M		2. Date of De Month	eath	3. Time of Death				
Medical Examiner	4a. Facility Name (if not institution, give street and number) Meritus Medical Center 5. Social Security Number 6. Sex 7. Ag			Location of Death	4c. County of Dea Wash	4c. County of Death Washington				
Funeral Director	5. Social Security Number 2 16 − 38 − 1084 Usual Residence of Decedent 6. Sex 1 □ M 2 😿 F 7. Ag	e (In yrs. last birthday) 69 Yrs.	Months Days	Hours Min. 8. Date of Bi. (Month, Di. Dec. 12	ay, Year) Co	rthplace (State or Foreign ountry) Maryland				
popular registrates a solution to the property of the solution	10a. State 10b. County Maryland Washington	10c. City, Town or Loc	Smit.	hsburg		10d. Inside City Limits 1 ☐ Yes 2 🗷 No				
tems 23a or er must be r Funeral C	10e. Street and Number 11931 Comanche Drive 11. Marital Status 12. Was Decedent E	Ever in U.S. 13. v		783 spanic Origin? (Specify Yes or No-	10g. Citizen of What C U.S.A.					
tural", or it	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates.	No It	f Yes, specify Cuba 1 ☐ Yes 2 X No	n, Mexican, Puerto Rican, etc.)	Black, Whi	Black, White, etc. Specify: White				
iener "natural" in the Medical Exi	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5	(Give H	dent's Usual Occupi kind of work done o O NOT use retired) Seamstre:	during most of working		16b. Kind of Business Industry Clothing				
Mental Hyg arked othe atic event,	17. Father's Name (First, Middle, Last) Albert Thomas Huntzbe	erry		18. Mother's Name (First, Middle Sophia Chr.	, Maiden Surname) istina Carb	augh				
Health and small s	19a. Informant's Name/Relationship (Type, Print) Deanna Bailey (Step Daught	ter) 15109	Falling	Number or Rural Route Number Rd. Wil.	liamsport,	Maryland				
rtment of h	20a. Method of Disposition 1	Brethren	gatoryor the plan Cemetery	22, 2011		o, Maryland				
Impo any ir once	Jellie Lee Druis	12		bury Ave. Smith						
nysician/ Medical	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)	ithe death. Do not enter. 1 10 with a consequence of:		g, such as cardiac or respiratory as		Approximate Interval Between Onset and Death				
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burial-transit										
ling phys e as the l	IF FEMALE:									
I by the attending phy: stached for use as the Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death 3 _	Ectopic pregnanc Other (specify)	у	23d. Date of de Month	blivery Day Year				
en signed b	Part II. Other significant conditions contributing to death b	ut not resulting in the u	i Lure,	en in Part I. 23e. Did 1	4.4	acco use contribute to the cause of death?				
cate has been si page 2 should I	Clost adium deffice	nlar Co.	agula to	24a. Was auto perfe	psy prior to death?	utopsy findings available completion of cause of				
nis certific I director, To Be	25. Was case referred to medical examiner? 1 Yes No Hospital:	ent 2 ER/Outpatien		ace of Death (Check only one) er: 4 \text{Nursing Home} 5 \text{Resi}	dance 6 Other/Spe	2/54)				
After thi uneral	27. Manner of Death 1 Natural 5 Pending 28a. Date of inju (Month, Day	ry 28b. Time of	28c. Injury work	v at 28d. Describe	how injury occurred					
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the Medical Certificate: To Be Completed by Physician/Medii	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injubuliding, etc.	iry - At home, farm, stre :. (Specify)		Yes 2 No 28f. Location (City or To	Street and Number or Ru wn, State)	ıral Route Number,				
hin 24 hours the Funeral apleted filled Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiners on the basis of examiners on the basis of examiners on the basis of examiners. To the	xamination and/or invest	tigation, in my opinio	 n, death occurred at the time, date : 	and place, and due to the	cause(s) and manner stated.				
With To to	29b. Signature and title of cartifier	MD	29c. License		29d. Date signed (Mont	n, Day, Year)				
γ State	30. Name and address of person who completed cause of de state filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Figistre	eath (Item 23a) (Type, P	rint)	00 63233 Voztheta	Aul Ho	5742M				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11:00P M ALINE MIIII OCTOBER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 9. Birthplace (State or Foreign Country) Estonia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Min. Days 1 🗆 M 2 🗶 F Director 011-26-2550 95 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Frederick Marvland Frederick 10g. Citizen of What Country?
United States 10e. Street and Numbe 10f. Zip Code Funeral 21701 should be filed within 72 hours after death with and Mental Hygiene.

is marked other than "natural", or items 23a 115 Record Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give White 3 ¥ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) Clothing Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Anna Lintsman Priidu Pihlamets permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5627 Woodlyn Road, Frederick, Maryland 21703 19a. Informant's Name/Relationship (Type, Print) Illar Muul / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 20. cemetery, crematory or other place)
Mt. Olivet Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2011 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licer Keeney and Basford PA Funeral Home MO1473 106 E. Church Street, Frederick, MD 21701 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause a cardiac or respiratory arrest. . Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Betweer Immediate Cause (Final Physician/ disease or condition resulting in death) ontw Medical consequence of): Examiner MA. www Sequentially list equiditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami FAU To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical P.O. Box 68760 as t the attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 \(\subseteq \) Yes 2 \(\subseteq \) No Day Year signed by the a Id be detached for 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HTN, Hy palpodemi, Petrol Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of death? Ostee Darasin 24a Was an autopsy this certificate has 1 Yes 2 No Yes 2 rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🗌 No Other: 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month. Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural
2 Accident 5 Pending Fell at numm 0900 AM Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 400 Her Kecens とうい? Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ce Le/16/11 04624x who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ october Yea 6:18PM 6(6 ero 2011 Medical cility Name (if not institution, give street and number, Town, or Location of Death **Examiner** 4c. County of Death)OHNS 1145 Baltimore Hospita Himore 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 188-09-5323 91 **Director** 1 X M 2 □ F 1919 12 14 Waynesboro, PA show 10a. State 10c. City, Town or Location at 10b. County 10d. Inside City Limits Director or 28a-f sh notified a PA Franklin Waynesboro X☐ Yes 2 ☐ No 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ems 23a or must be r Funeral 248 Highland Ave. 17268 US 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) al Hygiene. I other than "natural", or iter went, the Medical Examiner 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Specify: Completed 3 X Widowed 4 □ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working Elementary/Secondary (0-12) 10 life. DO NOT use retired) College (1-4 or 5+) expediter tool company event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Oliver W. Miller Bertha Mae Kauffman other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pat M. Destefan 11539 Westminster Dr. Waynesboro, PA 17268 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State Burns Hill Cemetery 10/20/2011 Waynesboro, PA 4 Donation 5 Other (Specify) 21. Signature of Fi 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 50 S. Broad St. Waynesboro, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between sepsis Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Date to (or as a consequence of): cause. Enter Underlying Examir attending physician and for use as the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Pregnant at time of death pau 9 Unknown g 🗌 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e, Did tobacco use contribute to the cause of death? b Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 2 No Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes ပ 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of I Director: After to be in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending hours after death. 1 Yes 2 🗆 No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD 21287 Rina Khatri

State

Registrar

31. Date filed (Month,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 October 1. 2:15 AM Daw Nwav Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Burtonsville Sanctuary at Holy Cross Social Security Number 7. Age (In yrs. last birthday **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 1 □ M 2 😾 F December 15. Bassein, Burma 91 Director 1919 084-60-1593 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Wheaton Maryland Montgomery 1 🗌 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20902 2813 Newton Street 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 1 ☐ Yes 2 💢 No If Yes, Give Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Asian Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natuu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wong Cheeming Ngwe Kway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Winnie Sein-Daughter 12809 Bay Hill Drive, Beltsville, Maryland 20705 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Atlantic Crematory Oct. 5, 2011 Glen Burnie, Maryland 21. Signature of Funeral rvice Licensee . Name and Address of Facility Fleck Funeral Home, Inc., 17601 Sandy Spring Road, Laurel, Maryland 20707 MO123 4 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Avance disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): ending physician a use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown Dav been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bhogaville

OCT 05 2011

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9801 Georgia Annu #1-17, Silverspring mn 2090

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>011</u> Physician/ Month Margaret Ruth Ritter 4:15 P M <u>Oct</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Golden Living Center Westminster Carroll . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🖾 F Days Min. Hours (Month, Day, Year) -24-191 Country)
MD 215-18-2903 95 Director Usual Residence of Decedent 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified MD Carroll Westminster 1 ☐ Yes 2 X No 5 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? 23a Funeral 1234 Washington Rd. 21157 USA items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 5 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3

Widowed 4 □ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Clothing 12 Seamstress traumatic event, Be led 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 and 2 should be Christian G. Wike Emma H. Autz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Darlene Rohrback-niece Fitzhugh Ave., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 ☐ Burial 2 Cremation 3 ☐ Removal from State South 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crem 10-5-2011 Sykesville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Fletcher Funeral Home homas D. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause Interval Between Immediate Cause (Final nset and Death ^ogysician, disease or condition resulting in death) monan Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No ō Month Year Pregnant at time of death page 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 1 Tes peen: Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No death? 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 8 No ၉ 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 3 🖂 Suiciae 4 🗌 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) th (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G924 2/15/2012 Jh State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ()9 2011 Teresa Ann Samosuk 2:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2120 Don Avenue Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min. 1 M 2 X F 80 Months Hours 0371771931 Yrs Director 218-28-782 Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f MD Carroll Westminster 1 ☐ Yes 2 X No 10e. Street and Numbe 10f. Zip Code ö 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 2120 Don Avenue 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?
1 ☐ Yes 2X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural". If Yes, Give 3 Divorced Completed Year or Dates White Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Public School System Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ပ Antonio DiPaula Vincenzina Maria Restivo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wesley Randolph Samosuk/husband 2120 Don Avenue, Westminster, MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 09/29/2011 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD Lakeview Mem. Park permit. Signatur of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Chapel 412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications th death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause of Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) signed by the a d be detached f 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has to committeed filled in by the funeral director, page 2 s autopsy performed? To the Hospital or Attending Physician: The 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ဂ္ 1 🗌 Yes 2 🗗 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier signed (Month, Day, Year) WJL

State Registrar

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DHMH 17 Rev 7/2009

Westminst

cause of death (Item 23a) (Type,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Day Year VELYN 09 0719 AM CULLISON 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death CARROLL ARROLL WESTMINSTER HOSPITAL CENTER Social Security Number 8. Date of Birth (Month, Day, 8 / 27 / **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 M 2 X F Hours Min. Country) MD 7-18-8636 **Director** 87 1924 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Carroll Hampstead 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3923 Sunset Drive 21074 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Completed 3 ☒ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Arthur Clemen Cullison Lola Emma White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4726 Fiscal Rd., Glen Rock, PA 17327 Leonard W. Smith III, son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Hampstead, MD e or Disposition (Name of stery, crematory or other place)

Mark's Snydersburg cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) st. M00741 21. Signature of Funeral Service Licens 22. Name and Address of Facility Eline Funeral Home Main St., Hampstead, MD 21074 934 S. emmer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition GASTROINTESTINAL Medical resulting in death) Examiner BREAST CANCER Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to for se a consequence of; Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events SEVERE ANEMI Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ Month Pregnant at time of death Day Year as been signed by the 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas certificate ha performed? Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🔀 No Other: 1 🗌 Yes မ 1 ★ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No __ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier WJL D44542 09/23/2011 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21157 Westminster, 200 Memorial Ave., RANGANATH AN

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Yea

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GERMAN OCTOBER 03 11AM 2011 10 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Examiner 4b. City, 4c. County of Death HARBOR BALTIMORE HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 X F Months 01/07/1926 85 **Director** 216-20-6864 Usual Residence of Decedent 28a-f shov 10a. State ms 23a or 28a-f sho must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Baltimore Catonsville 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 709 Maiden Choice Lane RG South 229 21228 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iterr ledical Examiner n 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 □ Divorced White Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 1 Mental Hygiene. marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Philip German Edna Singhass .. Page 1 and 2 should tment of Health and N tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Coan - Daughter 67 College Avenue Annapolis, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Crest Lawn Mem. 4 Donation 5 Other (Specify) 10/14/2011 Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_i si∟i∠n MONAR disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami sician and burial-tran Due to (or as a consequence of): attending physician Physician/Medical death certificate be P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birti 2
Pregnant at time of death ĺ in the past 12 months? Day the 9 Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ م Division of Vital Records, 2 4 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Be 1 🗌 Yes Other: 은 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) Medical 29a. Certifier Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 001 CTO BER 10,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 SOUTH HANDVER STREET, BALTIMORE, MARYLAND 21225 DR. HASSAN MASRI ID

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ray Robert Strausbaugh, Jr. 05 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9. Birthplace (State or Foreign Country) D A Social Security Number **Funeral** 8. Date of Birth 1**X** M 2 □ F Months Hours 10 777 794 4 204-34-9172 66 **Director** Yrs PA Usual Residence of Decedent 28a-f show 10a. State with the Maryland 10b County 10c. City, Town or Location notified at Director 10d. Inside City Limits MD 1 X Yes 2 ☐ No Worcester Ocean City ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 2401 Philadelphia Ave. #123 21842 USA items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed white Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'a may injury or other traumatic event, the Me any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Welder Welding Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental | Ray Strausbaugh Dorothy Wymer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21842 Jeannette Strausbaugh /wife 2401 Philadelphia Ave., #123, Ocean City,MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State First State Crem. 10/7/2011 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. I ter ye disease, or complications that caused shock in hear failure. List only one cause on each line disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition MALIGNAN Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Year Pregnant at time of death Yes 2 No ed by the a 9 Unknown 9 🗍 Unknown sate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autops after death.

Director: After this certificate Yes the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 27. Manner of eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No Accident Investigation Could not be filled in by the Suicide 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Confirm Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title DO058400 10-06-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1733 Strisbuy up 21802 MARY RAID 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OG tobe Helen Christina Smith 30 201 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown Social Security Number If Under 1 Year | If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Months Hours March Day Year) 1935 76 Maryland Director Yrs <u> 214-32-4406</u> Usual Residence of Decedent show 10a. State 10b. County te 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f 1 Tes 2XXNo Maryland Washington Sharpsburg 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a o Funera 6703 Dam #4 Road 21782 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2XXNo If Yes, Give "natural", 1 Yes 2XXNo Specify Completed 3 X Widowed 4 Divorced Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Cook Restaurant Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Irving Sigler Pearl Elizabeth Durbin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn Resau-Daughter 6707 Dam #4 Road Sharpsburg, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Spe Hagerstown Crematory Oct.12,2011 Hagerstown, Maryland Signature of Funeral Service Osborne: «Funerality Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he in failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ DEUMONIN disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner M GTA STUTTIC MOENOCARONA Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on Exami Citionic PULMONINZY DIJENS OBSTRUCTIVE -tran and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical that the death certificate be ERIENSI OF IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? Yes 2 No certificate 1 🗆 Yes 2 🗆 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner 2 TNO Hospital Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) Natural 5 Pending work' within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu ☐ Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one Signature, and title 29c. License number 00062006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAND ひてから WIRSON 11116 MEDICAL CAMPUS RD mos

Registrar DHMH 17 Rev 7/2009

State

Maryland 21215-0036

Baltimore,

68760

Box

P.O.

Records,

Division of Vital

egistrar's Signatur

HOTEL GRITOUN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2011 :48 P Oct 13, Oleta S. Snodgrass /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford 906 Cherry Hill Road Street Birthplace (State or Foreign Country) If Under 1 Year _ If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F Yrs. 95 Director 6/10/1916 Maryland 214-36-8883 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If them 27 is marked of the fran "natural", or items 23a or 28a-f show any injury or other traumatic event, fire Modical Ecumina mast be neithed as 1 ☐ Yes 2√ No MD Harford Street Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21154 906 Cherry Hill Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes AND If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 😾 💢 Specify: Specify.white ģ 3√Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be H. Clinton Scarborough Grace Kelly ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 906 Cherry Hill Rd., Street, MD 21154 Sarah Morris- daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition xxxBurial 2 ☐ Cremation 3 ☐ Removal from State Street, MD Emory Cemetery 10/21/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Faren Service Lice ee Harkins FH Inc., Delta, PA 17314 C. Kover 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANDIU-**Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner oter Ha Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Que to (or as a consequence of) burial-transi and resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) s been signed by the s should be detached ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed icate has been s ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 \(\text{Yes} \) 2 \(\text{\$\overline{U}\$} \) No After this certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\text{Nursing Home} \) 1 Nursing Home 5 \(\text{Residence} \) 1 Residence 6 \(\text{Other} \) Other (Specify) 1∐Yes 2000No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. Director: 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Homicide To the Hospital within 24 hours a To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100

State Registrar 31. Date filed (Month, Day,

rear)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	For State Registrar	State of Ma	aryland	_	rtment of H		l Mental Hy	giene 0		33779
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ING 21215-5UU36 Filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	Rt. 6, Box 634	5				26726			JSA	
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Ma 12 shouth and the should be shoul		Robert E. Stage		13		g Address (Street a		Keyser, V	·		Jule)
Te, 1 and of Heal item 3		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of natory or other place	,	Date	20c. Location		vn, State
IMOF Page 1 ment of ant: If it		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from State ecify)	1	•	emetery	· i OCL	. 17 2011	Kevse	r, WV	
Baltimore, permit. Page 1 and Department of Her Important: If item any injury or othe		21. Signature of Euneral Service Lice	isee /	1		. Name and Addres		Smith F			
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he death certicate the death certicate the attendinched for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 4 Pregnant at 9 Unknown	2 Fetal de	eath 3	Ectopic pregnanc Other (specify)	у			Date of delive	ry Day Year
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ISION Of VITAI Attending Physician: ar death. ector: After this certific by the funeral director,	Certificate:	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	t be 28e. Place of Inju		e, farm, stre		103 2 1110		(Street and Nun	nber or Rural	Route Number,
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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A	Medical	(Check 2 Medical Exa	hysician: To the best of aminer: On the basis of enurse Practioner : To the l	xamination ar	nd/or invest	tigation, in my opinio	n, death occurre	ed at the time, date	and place, and	due to the cau	se(s) and manner stated.
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Sta		Robert Welik, 31. Date filed (Month, Day, Year)	32. Sistra				CI Lailu,	111 413	02		
Registr	ar	OCT 24	2011 Due	N B	. 10	all					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33780 Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Shirley Virginia Scholtz ZOI 3000 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Meritus Medical Center Washington Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, ec. 19 1 🗆 M 2 🔀 F Days Hours Min 220-72-3715 80 **Director** Maryland Dec. Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits Director 1 Yes 2X No Washington Smithsburg Maryland 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be Funeral 22903 Civic Circle 21783 U.S.A. items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. Specify. 3 Widowed 4 Divorced White Completed er than "natur , the Medical I Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Monee. 0 Labor Janitorial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gussie Scholtz William Scholtz Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Copenhaver (Guardian) 820 Florida Ave. Hagerstown, Maryland 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State October Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 18, 2011 J.L. Davis Funeral Home Signature of Funeral Service Licenses 22. Name and Address of Facility MO1414 - Men 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ C disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as con equence of): -transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? be detached for Day Month Year Yes 2 the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 No □ Yes Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 2 10 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural work? 5 Pending 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 0054

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma		artment of Health		0011	22701		
			Registrar 1. Decedent's Name (First, Middle,	(act)	Cer	tificate of Death		Reg. 16. U	33781		
1	Physicia Media		Valetha Tyle	er			2. Date of Month Oct.	Day Year	3. Time of Death 3:25 P M		
	Examir	ner	4a. Facility Name (if not institution,	,		4b. City, Town, or Location		4c. County of Dea			
~	Funeral		6320 67th Court 5. Social Security Number		(In yrs. last birthday)	Riverdal	er 24 Hrs. 8. Date of l	Prince C	reorge 's		
	Director		107-34-2615	. 🗆 177	58 Yrs.	Months Days Hours		74, Year 1942 Sc	outh Carolina		
	nd now	Ļ.	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Loc	cation			10d. Inside City Limits		
	lanylar 3a-fsl ified	ecto		George's		iverdale			1 ☐ Yes 2 XNo		
	the N t or 28	Ξ	10e. Street and Number			10f. Zip Code		10g. Citizen of What C	Country?		
	h with	Funeral Director	6320 67th Cour	t		20737		U.S.A.			
	within 72 hours after death with the Manyland glene. er than "natural", or items 23a or 28a-f sho the Medical Examinar must be notified at	y Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Even Armed Forces?	11	Vas Decedent of Hispanic (Yes, specify Cuban, Mexic	Origin? (Specify Yes or N can, Puerto Rican, etc.)	lo- 14. Race - Am Black, Whi			
21215-0036	s after ral", o Exam	Completed by	3 Widowed 4 XDivorced	1 ☐ Yes 2 ☐√N If Yes, Give X Year or Dates.	1	☐ Yes 2 No Speci	fy:		Black		
2-0	hour "natu dical	plete	15. Decedent (Specify only highes	's Education	16a. Deced	ent's Usual Occupation aind of work done during me	ant of working	16b. Kind of Business	16b. Kind of Business Industry		
121	thin 73 ine. than	om	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. Do	ndow Clerk	ost of working	United St	United States Postal Service		
d 2	led wi Hygie other ent, th	Be (17. Father's Name (First, Middle, La		AATI		ther's Name (First, Midd				
/lan	should be filed within 72 hours after c and Mental Hygiene. is marked other than "natural", or aumatic event, the Medical Examin	유	Norris 7	yler		, 5. 110		ie Hightower			
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		19a. Informant's Name/Relationship			g Address (Street and Num			(ip Code)		
e, _	and 2 Health em 27 ther t		Tamara C. Stale	y-Daughter		67th Court,		·-			
Baltimore,	age 1 ent of nt: If it y or o		1 Burial 2 XCremation 3		20b. Place of Dispose cemetery, crem Matro Cre	natory or other place)	Date 10-8-2011	20c. Location - City of Baltimore	e, Maryland		
altin	permit. P Departm Importal any injur		1. Si portu e o il neral Service Lic	\sim		Name and Address of Fac			,		
<u>Β</u>	8 8 E 8 8		COMMEN	Marin	6	512 NW Crain	Hwy, Bowie	, MD 20715			
			23a. Part 1. Enter the disease, or c shock, or heart failure. List on	omplications that caused to by one cause on each line.	he death. Do not ente	r the mode of dying, such a	as cardiac or respiratory	arrest,	Approximate Interval Between		
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Mall	tiple	Myelon	19		Onset and Death		
	Examiner			Due to (or as a d	con equince of):	0					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a c	consequence of):						
	and and transi	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	C. ————————————————————————————————————	consequence of):		_				
0	cate be executed physician and the burial-transit	edical E	resulting in death) Last	Due to (or as a c	sonsequence oi).						
3760	ficate g phy: as the	Nedi		d							
Box 687	eath certific attending p I for use as	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2	pregnancy Fetal death 3	Ectopic pregnancy		23d. Date of de	elivery		
Bo	e deat the at hed fo	Physician/M	1 Yes 2 No	4 ☐ Pregnant at ti 9 ☐ Unknown	ime of death 5	Other (specify)		Month	Day Year		
P.O.	law requires that the death certificate be executed nas been signed by the attending physician and 2 2 should be detached for use as the burial-transi	by Ph	Part II. Other significant condition	s contributing to death but	not resulting in the ur	nderlying cause given in Pa	rt I. 23e. Dio	tobacco use contribute t	o the cause of death?		
ds,	requires been sign should be	ed b					1 [Yes 2 No 3 □ I	Probably 4 🗆 Unknown		
COL	aw requias been 2 should	Completed					24a. Wa	as an 24b. Were at topsy prior to	utopsy findings available completion of cause of		
Be	The page						pe	rformed?/ death?			
/ital	ysician: iis certific director,	0	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		Other:	eath (Check only one)				
of\	al this	e: To	27. Mann of Death	28a. Date of injury	t 2 ER/Outpatient	28c, Injury at		sidence 6 Other (Spe e how injury occurred	cify)		
no	eath. or: Aft he fur	fical	1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no		Year) injury	work? M 1 ☐ Yes 2 l	□No				
Division of Vital Records,	or Att after d Direct in by 1	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		- At home, farm, stre Specify)	et, factory, office		(Street and Number or Ruown, State)	ural Route Number,		
	io the nospiral or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,		29a. Certifier 1 Certifying P	hysician: To the best of my	v knowledge death o	occured at the time, date an	d place and due to the	cause(s) and manner as et	tated		
	ne rio in 24 } he Fui ipletec	Medical	(Check 2 L Medical Exa	miner: On the basis of examiner: On the basis of examiners of the be	mination and/or investi	gation, in my opinion, death	occurred at the time, date	e and place, and due to the	cause(s) and manner stated.		
	with com		29b. Signature and title of certifler			29c. License number		29d. Date signed (Mont	th, Day, Year)		
	ンノ	1	Mann	<i>S</i>		07010		10-04-	2011		
	10	- 1	30. Name and address of person wh	o completed cause of deal	th (Item 23a) (Type, Pr	int)					
	,		Dr. Ivan Zama,	9200 Basil C	Court, Suit	e 200, Largo	, MD 20774				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10Mase11 530AM atha 7105 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Anne Arundel 2008 Quay Village Court Annapolis 7. Age (In yrs. last birthday) 63 yrs. . Social Security Number 078–40–7091 8. Date of Birth (Month, Day, Year) Sept. 2, 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Days Hours New York Director 1948 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Annapolis Anne Arundel 1 Yes 2 KNo 10e. Street and Number 2008 Quay Village Court 10f. Zip Code 10g. Citizen of What Country? 21403 Funeral 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2XXNo Specify: Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other transment. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Sector Director of Security Northrop Grumman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Surname)
Josephine J. Pelligrino Hugh C. Blake ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1324 Irving St., NW Washington, DC Tara Masterson/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place. Baltimore Crematory Baltimore, Maryland 10/6/2011 4 Donation 5 Other (Specify) 21. Signature of uneral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Breast Physician/ disease or condition 2 4865 Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 28 40 Other: ပ္ 1 Ves 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annalis MD 2140 2003 31. Date filed (Month Day Ye State 0 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygier (Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ rear 1 10 4 Рм Lawrence H. Vincent Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard Columbia 9010 Moving Water Lane 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Mg)th 24-1949 Days Hours Min 1 🗀 🌠 2 🗆 F Months **Director** 019-40-2447 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location be notified at Director 1 🗆 Yes 2 💆 No Columbia MD Howard ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral er than "natural", or items 23 the Medical Examiner must 21046 United States 9010 Moving Water Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?
1 □ Wes 2 □ No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Tyes, Give 1970-2002 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry within 72 other than Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene Software Engineer BAE Systems Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental marked ပ Kathleen Claire Joyce Robert Vincent 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 9010 Moving Water Lane Columbia MD 21046 19a. Informant's Name/Relationship (Type, Print) 1 and 2 sl of Health a item 27 i Sue Ann Vincent/wife permit. Page 1 and Department of Healt Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Arlington, VA ANC 4 Donation 5 Other (Specify) Witzke's Family FH Inc. 22. Name and Address of Facility Harry H. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final disease or condition Onset and Death Physician/ corcinamo 20X Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): death certificate be executed the burial-transit Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ Unknown P.O. Physician: The law requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 2 No 1 Yes of Vital completed filled in by the funeral director. 25. Was case referred to medical l a 26. Place of Death (Check only one) examiner? 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: or Attending 1 X Natural 5 Pending Division after death. 1 Yes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town. State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia MIS 21045 2 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2^{Pay} 2011 8:50 AM Geraldine M. Windisch Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 10806 Harney Rd. Frederick Emmitsburg If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year 9/4/1924 1 M 2 F Director 205-16-4724 87 Usual Residence of Decedent show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10h County 10d. Inside City Limits Director MD Frederick Emmitsburg 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 10806 Harney Rd. 21727 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by Yes 2 XNo Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker House Work Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Lewis D. Eyler Mary E. Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harney Rd., Emmitsburg. Linda Sanders / Daughter 10806 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 10/1/11 4 Donation 5 Other (Specify) Gettysburg, PA awn Memorial Candens Signature of Fulleral Service Licenses 22. Name and Address of Facility 34 Maple Ave. Littlestown,PA Little's F.H. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ myocarola INFARLTION disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 10 um COCOUNZA Sequentially list conditions, Examine Due to for as a consultence of cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dislates I 1 Yes 2 100 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 Be 26. Place of Death (Check only one) Hospital ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director. At completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9 (28) 11 043643 WJL

State

Registrar

10

76 Frederick St.

Back

TAMEUTONN, MO

21787

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mip

32. Registrar's Signature

THE

A

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 23:34 M ILLIAM 2011 October Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** THE JOHNS HOPKINS MOSPITAL BALTIMORE 17 If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours 168-34-2303 **Director** 1 X M 2 D F May 23,1941 Pennsylvania Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10b. County 10d. Inside City Limits be filed within 72 hours after death with the Maryland must be notified at Director Maryland Washington Hagerstown 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1097 Marshall Street U.S.A. 21740 Mental Hygiene. narked other than "natural", or items natic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Furniture Store salesman other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mickey Julia Walter Harry t. Page 1 and 2 should tment of Health and Mant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Walter - wife 1097 Marshall Street, Hagerstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Hagerstown Crematory October 13, | Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final BURKITT Physician LYMPHOMA Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cauca. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ been signed by the atte should be detached for in the past 12 months? Month Dav Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? p. I or Attending Physician: The law requires after death.

Director: After this certificate has been sign 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗆 Yes 2 🗆 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Certificate: 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie D70622 October 7, 2011

State Registrar

DHMH 17 Rev 06-2011

JENNIFER

31. Date filed (Month,

600 NORTH WOLFE

ST. BALTIMORE MD 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Reg

trar's Signature

- KANAKRY

OCT 12 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 8^{pay} 2011 Year October Kimberly Marie Wertz a. Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner 15803 Shinham Rd. Washington County Hagerstown Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9, Birthplace (State or Foreign 7. Age (In vrs. last birthday, **Funeral** Days Hours Min. 216-90-4688 Months 49 **Director** 1 □ M 2 🗙 F Maryland May 21,1962 Usual Residence of Decedent 28a-f show 10d, Inside City Limits 10b. County 10c. City. Town or Location must be notified at Director 1 ☐ Yes 2 X No Maryland Washington County Hagerstown 10e, Street and Number ö 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 15803 Shinham Rd. 21740 U.S.A. death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Force: Black, White, etc. "natural", or þ 1 Never Married 2 X Married 2 XNo 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed 3 Wildowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
27 is marked other than 'traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Balistrieri Shirley Oldenburg Balistrieri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Robert E. Wertz, Jr-husband 15803 Shinham Rd. Hagerstown, MD 21740 20a. Method of Disposition
1 □ Burial 2 X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Smithsburg Crematory 10-10-2011 | Smithsburg, MD 4 Donation 5 Other (Specify) 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between set and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequent Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on executed and trans that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as 1 IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ģ Pregnant at time of death the a | Linknown 9 Unknow s been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a, Was an has le 2 autopsy page performe 1 Yes 2 No this certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical 1 > Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29c. License number 64 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) egistrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33788 State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Octobe 7.30 Ralph Eugene Weagley Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Washington Meritus Medical Center Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F Months Hours Min Yrs **Director** PA 214-28-1026 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location er than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10a State 10b. County 10d Inside City Limits Director 1 Yes 2 X No MD Washington Hagerstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 15143 Blovers Ave. 21740 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 72 hours after If Yes, Give 1952-1960 Year or Dates: 1 Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) 12 th Station Attendant Gasoline / Retail event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Cleveland Weagley Emma Pauline Mowen permit. Page 1 and 2 should by Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elta M. Weagley / Wife 15143 Bloyers Ave., Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/13/2011 Smithsburg, MD Smithsburg Crematorium 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licenses 305 North Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a. ARYERIO SCLEROTIC CARDIOVASCULAR disease or condition Medical resulting in death) DISEASE Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last and -trar Due to (or as a consequence of): anding physician use as the burial Physician/Medical requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown signed by the a d be detached f P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEWENTIA Records, STAGE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an To the Hospital or Attending Physician: The law is within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 s autopsy performed Yes 2 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Anatural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D18019 altMO 06710,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Qx MILL ST MAGERS TOWN, MO 21740 DATTA 20 3 U 0 31. Date filed (Month, Day egistrar's Signatur State Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month Day, Yang

DOME

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCT OBER Physician/ 604 Tis -Medical institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 24 Hrs. 8. Date of Birth 9, Birthplace (State or Foreign Funeral (Month, Day, Year) North Carolina Months Hours **Director** Show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified BALTIMORE 28a-f Yes 2 No MD 10e. Street and Number 10g. Citizen of What Country? ò must be Funeral 23a U.S.A. 21229 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner musone. filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No 1 Never Married 2 Married þ 1 🗌 Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NURSING 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 12 29 19a. Informant's Name/Relationship (Type, Print) DAUGHER DELLA F. Williams. Smith St. BALTIMORE, MARYIAND 001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) PIKESUILLE, MARYLAND permit. 22. Name and Address of FaciliTAE DERRICK C. JONES FVH, P.H. 21. Signature of Funeral Service Licensee AUE. BALTIMORE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STAGE PARKINSON'S Physician/ END INKOWN Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy funeral director, page 2 1 Yes 2 No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director. After this certifica completed filled in by the funeral director, to 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) AGNES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 11:40 AM 24,201 /Medical Win, or Location.

TONS VIT L L

Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

03-26-42 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner VEN NURSING HOME Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 € M 2 □ F 197-30-4249 unk. 69 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygleine. Important: if item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exemination 1. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21217 701 Edmondson Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status unk. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: ģ Specify: Caucasion 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk. unk. 17. Father's Name (First, Middle, Last) unk. 18. Mother's Name (First, Middle, Maiden Surname) unk. Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21202 19a. Informant's Name/Relationship (Type. Print) Terry K. Sullivan-Guardiah 10 N. Calvert Street Suite#200 Balto:MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐Removal from State Metro Crematory 10-27-11 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzhamers Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the ed by the attending per detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No 24a. Was an autopsy perform 22 No 1∏ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☐ Yo Other: 2 ER/Outpatient 3 DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attency within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mules 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith Avene MS 21209 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33792 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Wanda Marie Alvev 6:05 October 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Transitions Healthcare Sykesville Social Security Number If Under Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Yaar) 59 1 □ M 2 🂢 F Hours Min. Months Director 212-84-7246 51 Marvland Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Carroll Sykesville 10e Street and Number 10g. Citizen of What Country? Funeral 6246 Sykesville Road 21784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withi.
Department of Health and Mental Hygiene
Important: If item 27 is marked other the Clerical JH Applied Physics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gerald Louis Dunn, Sr. Carron Neal Hinegardner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Dunn, Jr., Brother 18 Enjay Avenue Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 10/22/11 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Cardiovasinlar Disense Onset and Death Athenisclerahz Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and -transit Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical that the death certificate be IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 1 Yes 272 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by rabetes Mellitus Records, 1 ⊠Yes 2 □ No 3 □ Probably 4 □ Unknown pertensin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 2 0 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After **▼** Natural 5 Pending injury work?
1 Yes 2 No s after death.

I Director: Aft
d in by the fur 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43725 10/21/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD westminster 19, Ridue MALmoud 2115 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 5 2011

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 20, 2011 6:30 PM **JAIME** ARBONA Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner N/A Baltimore 6300 Mayflower Avenue 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral 1XX** M 2 □ F 05/231/1923^(ear) Months Puerto Rico 88 **Director** 217-26-8736 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director XX Yes 2 No Maryland Baltimore None 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21212 6300 Mayflower Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 XX Yes 2 \(\subseteq \) No If Yes, Give Black, White, etc. è 1 Never Married 2 XX Married Baltimore, Maryland 21215-0036 XX Yes 2 No Specify: Puerto Rican Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Customs Agent Federal Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Octavia Medina Carmelo Arbona delValle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR 1568 Putty Hill Avenue Towson, MD 21286 Cynthis Mavrophilipos 20a. Method of Disposition

1 XX Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Moreland Mem Park 10/28/2011 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell - Wie efeld Funeral Home Inc ignature of Funeral Se 6500 York Road Baltimore, Maryland 21212 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav 5 Other (specify) Pregnant at time of death 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performed' 1 ☐ Yes 2 ☐ No certificate | Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA In the now, within 24 hours after death.

To the Funeral Director: After this of the funeral directory and the funeral directory. ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury_at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my kpowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Mation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of exa 3 Certifying Nurse Praction of: To the st of my knowledge, death occ red at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who compl ted cause of c h (Hem 23a) (Type, Print) 1/34 York Road, Lutherville, Maryland 21093 Ayman Akkad, MD, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 21. 2011 Daniel 1:47 P M Maurice Abbott, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Baltimore Towson Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 213-68-1703 **Director** 1 XM 2 □ F 55 Feb. 27,1956 Maryland Usual Residence of Decedent 28a-f show 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Lutherville Baltimore 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 Horseshoe Circle 21093 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Mechanical Plumbing & Heating Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Department of Health and Ment: Important: If item 27 is marked any injury or out. Daniel Abbott, Sr. Maurice Joan Amelia Hack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan A. Abbott Mother 3 Horseshoe Circle Lutherville, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 10-24-2011 Towson Maryland of Funeral Service L 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or in that initiated events and Due to (or as a consequence of) resulting in death) Last physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Yes 2 No be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) (2 Hospital 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) osdice this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 🔲 Yes Investigation 6 Could not be Director Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medican xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, de occurred at the time, date and place, and due to the cause(s) and manner as stated e and title of certifie 29d. Date signed (Month. Day, Year) 67 OIN 100 10 Month, Day, Year 32. Registrar's Signature State 2 5

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TITEM#31perDVR, 6920, 10, 725, 2011, WS State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Charles Phillip Anderson Month Physician/ 0452 PM 10 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE ST AGNES HOSPITAL If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 2Social Security Number 2 last birthday Months Days Hours Min 1 1007 2 0 V Country 1**X**☐ M 2 ☐ F 948 Yrs MD Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d Inside City Limits 10c. City, Town or Location Funeral Director MD Baltimore 1 X Yes 2 □ No 10f. Zip Code 21229 10e. Street and Number 840 Lyndhurst Street 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 _{Specify}Black Yes 2 No Specify: 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clinical Director Counseling Be 18. Mother's Name (First, Middle, Maiden Surname)
Della Thomas 17. Father's Name (First, Middle, Last) John Anderson မ 19a. Informant's Name/Relationship (Type, Pri , Print) Villiams Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9519 Whitehurst Dr., Owings Mills, MD21117 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State At 1 antiver crecing attory 10/24/201 1 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland
PO Box 14 21. Signature Funeral Service Licensee Dorota Marshall Services remation 3. Balti 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. 1 day Immediate Cause (Final Physiciana disease or condition resulting in death) UPPER GI bleed Medical Due to (or as a consequence of) Examiner Pulmonary Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown be detached for Month Day Year signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records. page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? Yes 2 No this certificate 1 Yes 2 No Division of Vital completed filled in by the funeral director. 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 🗌 Yes 2 📝 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) s after death. I Director: After the 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Meenalshi, Resident Physician P-26615 10/22/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Meerakshi Dagas s. caton Baltimore aure 31. Date filed (Month, Day, Year) 25 2011 State 10/22/2011 Registrar

ANDERSON,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 5:14 A M october 22 2011 BRYAN JAY AKMAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Sinai Hospital of Baltimore N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 05/07/1956 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours Months Days X M 2 □ F MD Director 217-62-4578 55 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location 28a-f show ? is marked other than "natural", or items 23a or 28a-f shot traumatic event, the "hadical Examiner must be multified at 1 ∏Yes 2X No Completed by Funeral Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21208 8 HURLINGHAM COURT 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) ATTORNEY T.AW and Mental Hygivis marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental MARION BLUMBERG AKMAN AT.VTN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau 8 HURLINGHAM COURT, BALTIMORE, MD TERRI AKMAN/WIFE Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BETH EL MEMORIAL PK 10/24/2011 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aartic dissection, Type A 12 hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unitaritying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): burial-1 Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the detached f 2 □No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☑ No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

BRYAN

AKMAN

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2 5 2011

Peter W. Chis, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter W. Cho, M.D. 2435 West Belvedere Avenue Baltimore, Manylound

Surgeon

32. Registrar's Signature

29c. License number

D41129

29d. Date signed (Month, Day, Year)

October 22, 2011

			State Registrar					Certific	ate of L	Death		Reg. N	lo.			
	Dharisi	.,	1. Decedent's Nam	e (First, Middle							2. Date of D		laid -	Mar. 1		- 0.1
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	Funeral		5. Social Security N 218 – 14 –	ungber 4706	6. Sex 1 X M 2		rs. last birth	rs. If U	nder 1 Year ths Days	If Under 24 Hr Hours Mir		lirth Day, Year,		9. Birth	place (State o	r Foreign
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	of He of He of He		20a. Method of Disp	position		20	Ob. Place of	Disposition	(Name of or other place	201	Date	20c.	Location - 0	City or To	own, State	
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	per it. Page 1 and 2 should be filed within 72 hours after death with the Maryland per it. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	neral Service I	icensee											
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			23a. Part 1. Enter t shock, or hea	he disease, or rt failure. List o	complications than	each line.				g, such as cardia	ac or respiratory	arrest,			Approximat	te tween
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0	Medical Examiner		resulting in death)		Due Due	to (or as a con	sequence of):	^							0.1
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Frederick Broccolino 7:01 P.M October 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 2408 Mayfield Avenue Baltimore Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Min. Hours Months Days 58 220-64-033 Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County be filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 XYes 2 No It I MORE MID 10g. Citizen of What Country? 10e. Street and Number permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Beganness: If item 27 is marked other than "natural", or items 23a any injury or other traumatic awant the Media. Funeral 21213 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates. 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden So 2 Bruccolino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Broccola INDA 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State BAHIMORE, Greenmount Cemetery In: 10-26-2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. FH Conkling St., Baltimore, MD 21224 263 23a. Part 1 Enter the disc shock, or heart Immediate Cav'e disease or condition resulting in death) ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between on each line. List only one ca Onset and Death Ph. ician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to lor as a consequence of cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 \ No certificate has 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifice completed filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 ☐ Yes 2 💢 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10-25-11

State Registrar Baltmore, Mp 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Perul Weismer 5 tool Loch Perul B

32. Registrar's Signature

Date filed (Month, Day, Year)

2 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month / D Physician/ LZE BARNEY 2°o 2011 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A 2106 Redthorn Road Baltimore Social Security Number Birthplace (State or Foreign
 Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) 1 🗆 M 2 🗗 F **Director** 251-42-8035 89 Yrs. 1/24/1922 S.C. Usual Residence of Decedent 28a-f shov death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD N/A Baltimore 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 21220 2106 Redthorn Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other transmans. by 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Black Specify. 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HouseKeeping State of MD N/ABe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mayo Nettles Sorena Nettles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6211 Fair Oaks Ave. Baltimore, MD 21214 Janie Lee-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burlal 2 Cremation 3 Removal from State Memorial Pk. 10/26/2011Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee March F/H East 1101 E.North Balto MD Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ZHE'MERS Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate Examine Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 month Month Day Year Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier (Check 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burnal-transit Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) October 20, 2011 50E10 45U wee MD D 15904 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ONS ONS ALL DING HTT NG ME, MD 4703 BREAD BROOK DR BETHESDA MO 20814 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 33800 Certificate of Death Decedent's Name (First, Middle, 2. Date of Death 3. Time of Death Physician/ Month 925 AM Medical 1011 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MOB **Funeral** 7. Age (In yrs. last birthday, If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) 8 03 Months Min. 1 M 2 XF Country) Director 192-20-5100 90 VA Usual Residence of Decedent 28a-f show 10b. County 10a, State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Xes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 709 East Chase 21202 U.S.A. Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Black, White, etc. Completed by 1 Never Married 2 Married Yes, Give No Baltimore, Maryland 21215-0036 1 Yes 2 No "natural", Black 3 🔀 Widowed 4 □ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the 8th grade na Homemaker House Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file 2 Rachel Murray John Hedgmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , co permit. Page 1 and 2 sl Department of Health a Important; If item 27 is any injury or other tra 709 East Chase Street, Baltimore, Md 21202 Linda Dickens-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/1/2011 <u>Garrison Forest Vet</u> Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 WaBASH Ave, Baltimore, Md 21215 Part 1 Enter the disease, or complications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Physician/ 6 MENEIA Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Birth 2 Pregnant at time of death ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ed by the detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Tyes of Vital Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural injury work? 5 Pending Division To the Hospital or Attendii within 24 hours after death. To the Funeral Director; A Accident 2 No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HollANd-8813 WALLAND Woods Bd PARKUILL MD 21234

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State

Registrar

31. Date filed (Month, Day, Year)

5

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Saker 201 Medical 4a. Facility Name (if not institution, give street and number) 200 **Examiner** b. City, Town, or Location of Death 4c. County of Death BURS 21233 More 6. Sex If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖵 🖈 Months **Director** 217-12-6501 89 Usual Residence of Decedent show 10b. County of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Baltimore MD NA 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21217 U.S.A. 2104 Bryant Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 Never Married 2 Married Completed by Yes 2 No altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cleaners 12th grade Laborer na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Gertrude Johnson Stephen Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4100 Tiverton Road, Randallstown, Md 21133 Brenda Elliott-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet. 10/28/2011 Crownsville, Md 21. Signarura of Funeral Service Licensee 2. Name and Address of Facility to 300 Wabash Ave, Baltimore, Md 21215 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock or heart failure. List only one cause on each line. Immediate Cause (Final Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical as a consequence of); Due to (a) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Linknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ es 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has erter 1 Yes 2 No Yes 2 1 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was c referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred 5 Pending injury Natural 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State Registrar etimore

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

32 Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33802 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 18^y 2011 Robert Mark Benbow October 0 10:24 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville Oak Crest Care Center Social Security Number If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 Tours 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 1 🛛 M 2 🗆 F Months Hours 05-25-1925^{ar)} 539-12-8097 Iowa 86 **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director Parkville Baltimore 1 🗌 Yes 2 🗶 No Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21234 USA Apt. 233 8830 Walther Blvd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 Now III

If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. White 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Education Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clara Louise Thomasen Earl William Benbow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Katherine Ehrenberger - Daughter 5304 Hamlet Avenue Baltimore, Maryland 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hillton Service Corp. 10-21-2011 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 5305 Harford Road 22. Name and Address of Facility 11/81/01 Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy Division of Vital Records, P.O. Box in the past 12 months?
1 ☐ Yes 2 ☐ No cate has been signed by the atterpage 2 should be detached for it Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed3 1 Yes 2 No After this certificate I or Attending Physician; after death. Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year) 2011 3110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W M 21234 wa 1th 32. Registrar's Sign State Registrar

amend 5, per fh, g921 11-9-11 sm
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 30 per dyr g920 10-25-11 yt
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar 33803 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Bower ANCE Medical 10 300 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Balti more Mos 7. Age (In yrs. last birthday)

57 Yrs If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Min. 1 **№** M 2 □ F Days Months Hours (Month, Day, Country) Director 6-24-1954 Usual Residence of Decedent 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD n/a Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16 Henson Avenue 21225 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Nivorced Specify: African-American Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Coldwell Banker Real Estate Agent injury or other traumatic event, Be permit. Page 1 and 2 should be filed
Department of Health and Mental Hy,
Important: If item 27 is marked oth,
any injury or other the contract of the contract 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Meldenardo E. Bowen Constance William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lance S. Bowen Jr./Son 5049 Meadow Crossings Lane, Roanoke, VA 21019 20a. Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Arbutus Menorial Park 10-26-2011 Arburtus, MD 4 Donation 5 Other (Specify) of Furieral Service Licensee 22. Name and Address of Facility Wlie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Due to (or as a consequence of): Arteru DISCAS that initiated events resulting in death) Last physician s the burial To the Hospital or Attending Physician: The law requires that the death certificate be ex Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of cert 29d, Date signed (Month, Day, Year) 054775 October 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 900 Franklin Square Dr. Baltimore, Md. 21237

DHMH 17 Rev 7/2009

State Registrar

Jose J. Lopez 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Item 25 State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month OCT Day Physician/ 11.46AM Margaret C. Brown 14 2011 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** AGNES HO 5011 BALTINSRE N/A If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 ⋤ F Months Days Hours Maryland 027267 1921 90 219-16-5423 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10b. County 10c. City, Town or Location 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State Director 1 XYes 2 No Baltimore N/A MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 21225 3044 Ascension St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces' Black, White, etc. 1 Never Married 2 Married Yes 2 No ò Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Baltimore City 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 f Department of Health and Mental Hygiene. Important; if item 27 is marked other than "ns any injury or other traumatic event, the Manalone." (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Schools Teacher 5+years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Cecelia Wilson Earl Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2638 Cecil Ave., Baltimore, MD 21218 Iris Davis(sister in-law) Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 10/21/11 Baltimore, MD 4 Donation 5 Other (Specify) Cedar Hill Cem. 21. Signature of Funeral Service License Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD retuch 21217 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line NTRAVENTRICULAR Onset and Death Immediate Cause (Final HE MURRHAGE Physician/ TWO DAYS disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Esquentiany liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): CERTIFICATION CORROLED BY MEDICAL EVAMINER attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending nhysicial 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Year g Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 No $\mathcal{R}_{\mathcal{O}} \sim \mathcal{M}$ Division of Vital F 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, examiner? 1 X Yes Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Lettifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ATTEMOINS 14 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M3 2128 TANSINDA AVE # 204 3455 MILLICENS JAMES 31. Date filed (Month, Day, Year) 32 Registrar's Signature State parker OCT 21

DHMH 17 Rev 7/2009

Registrar

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		1	For State Registrar	State of Ma	arylan		artment of I tificate of I	Health and N Death		2011	33805
Physic	ian/		. Decedent's Name (First, Middle, Las	t)	-		imeate of t	Journ	2. Date of Death	g. No.	3. Time of Death
Med	lical		Ellen Ch	in Boo	ck				October	T	
Exam	iner		19607 Cameron Mi	,			46. City, Town, o	r Location of Death		4c. County of D	imore
Funera Directo	_	5	. Social Security Number 6. Se 213–16–5614	7. Age	(In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. 1016 M	Birthplace (State or Foreign Country) ary Land
		_	Jsual Residence of Decedent Oa. State 10b. County	Α					red 10,	1010 [14	
larylan 3a-f sh iffied a	ecto		MD Balti	more	10c. Cit	y, Town or Loc Cocke	eysville				10d. Inside City Limits 1 ☐ Yes 2 🖾 No
th the Manager 28	Funeral Director	1	Oe. Street and Number 801 Staffordshire	Pood			10f. Zip Code 2103	20	10	g. Citizen of What	Country?
eath wir	uner	1	1. Marital Status	12. Was Decedent Ev	ver in U.S	S. 13. V		ispanic Origin? (Spe	cify Yes or No-	U.S.A.	merican Indian,
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	þ	١.	1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates.	No	If	Yes, specify Cuba ☐ Yes 2 🔀 No	an, Mexican, Puerto	Rican, etc.)	Black, W	
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lary should and Me is mar			9a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailin	g Address (Street	and Number or Rura			Zip Code)
e, M and 2 s Health em 27 ther tr		-	Lindsey B. Fox-da Oa. Method of Disposition	ughter	Took D			n Mill Rd			21120
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental hygiene. mportant: If item 27 is marked other than "natural", on my injury or other traumatic event, the Medical Example.			1)	Dul	anetery, crem aney V	ition (Name of atory or other place alley	10/2	7/11 T	inonium,	MD
Ball permit Depar Impo		2	1. Signature of Funeral Service Licens	≫William	G. I		Name and Addre	ss of Facility Ruc Rd., Tows	k Towson	Funeral 21204	Home, Inc.
Physician Medica Examine			23a. Part 1. Enter the disease, or comp. shock, or heart failure. List only or mmediate Cause (Final disease or condition esulting in death) Sequentially list conditions, fany boding to minimize the cause. Enter Underlying	a. Due to (or as a	consequ	ob ence of):	74 E	g, such as cardiac o			Approximate Interval Between Onset and Death
760 cate be executed physician and s the burial-transit	edical Exan		Cause (Disease or linjury hat initiated events esulting in death) Last	Due to (or as a	consequ	ence of):					
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ds, P.O uires that t in signed b	ed by P	P	art II. Other significant conditions co	ntributing to death bu	t not resu	ulting in the un	derlying cause giv	ven in Part I.			to the cause of death?
Division of Vital Records, P.O. all or Attending Physician: The law requires that the strict death. In Director: After this certificate has been signed by it in by the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached.	Completed by	-	Congestive	Heart	For	lu	2		24a. Was an autopsy performe	prior t ed? death	autopsy findings available to completion of cause of ? Yes 2 \(\sum \) No
Tital Residents The certificate	Be	2	5. Was case referred to medical examiner? 1 □ Yes 2 ⋈ No	ospital:			Oth	ace of Death (Check	only one)		2 11 12
of V ng Phys ter this	te: To	2	7. Manner of Death	1 Inpatier 28a. Date of injury (Month, Day,		ER/Outpatient 28b. Time of injury	3 DOA 28c. Injury	4 □ Nursing Hor	me 5 Residence 28d. Describe how		ecity) Laughter's long
sion ttendir death. stor: Af	Certificate:	l	2 Accident Investigation 3 Suicide 6 Could not be				M 1 🗆	Yes 2 No			
Division A state as all Direct ed in by			4 Homicide determined	28e. Place of Injury building, etc.	(Specify)	ne, iarm, stree	et, factory, office	1	281. Location (Stree City or Town, S		Rural Route Number,
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	2	9a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 3 Certifying Nurse	er: On the basis of exa	mination	and/or investig	nation in my opinio	n death occurred at	the time date and r	lace and due to th	e cause(s) and manner stated
To t To t		29	b. Signature and title of certifier				29c. License	number		I. Date signed (Mo.	nth, Day, Year)
		30). Name and address of person who co	mpleted cause of dea	ith (Item	23a) (Type. Pri		5808		10124/3	2011
100		21	Anne Cow 15, 4	2mp 67	01	N.CL	urles	St., Stc	4105,	Baltin	are MD 212A
Sta Regist		٥	OCT 2 5 2011	32. Registra	s Signatu	ark		-			

DHMH 17 Rev 7/2009

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		-		epartment of Health and N Certificate of Death	ental Hygieı . _{Reg.}	2011	33806
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia Medio		Thomas Talbott Bond		October 2	21, 2011	9:45 A™
	Examin	er	4a. Facility Name (if not institution, give street and number) Keswick	4b. City, Town, or Location of Death Baltimore		4c. County of Deat	th
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea May 24, 1	9. Bir 926	thplace (State or Foreign untry) Maryland
	nd how at	٦	Usual Residence of Decedent 10a, State 10b. County 10c. City, Town o	r Location			10d. Inside City Limits
	/anyla Ba-f s tified	ect	MD Baltimore Stevenso	nn			1 ☐ Yes 2 🔯 No
	a or 2	ا ق	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Co	ountry?
	h with	Funeral Director	2212 Wiltonwood Road	21153	US	SA	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ances.	þ	1 ☐ Never Married 2 ☒ Married	 Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto □ Yes 2 X No Specify: 		14. Race - Ame Black, White	e, etc.
8	atura cal Ex	etec	3 ☐ Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Divorced 16a.	ecedent's Usual Occupation	161	Specify: who	
215	n 72 h an "n Medi	Completed	(Specify only highest grade completed) (G	ive kind of work done during most of work e. DO NOT use retired)	ing	o. Kind of Business	industry
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and	e filed tal Hy ed otf	To Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	ten Surname)	
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Baltimore, Maryland 21215-0036	of Heal of Heal fitem?		20a. Method of Disposition 20b. Place of D			c. Location - City or	
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Ball	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other		21. Signature of Fir era Service lice (eg	22. Name and Address of Facility			York Road
			23a. Part 1. Enter the disease, or complications that caused the death. Do not	Ruck Towson Funeral enter the mode of dying, such as cardiac		ic. Tows	on, MD 21204
	Physicin		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	monka			Interval Between Onset and Death
المردي	Medical Examiner		resulting in death) a. Due to (or as a consequence of):	WNWNEGO			
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90	cate be executed physician and s the burial-transit	edical Examiner	d				
Box 68760	ertifica ding pl		IF FEMALE: 23b Was decedent pregnant 23c. If yes, outcome of pregnancy				
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rds	require	eted					Probably 4 Unknown
Division of Vital Records,	e law e has t ge 2 s	ldmo	Preumonon		24a. Was an autopsy performed	prior to death?	itopsy findings available completion of cause of
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Σį	al or A safter i Direct d in by		4 Homicide determined building, etc. (Specify)	, street, factory, office	City or Town, St		irai noute ivuiribei,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de- (Check 2 Medical Examiner: On the basis of examination and/or in	ath occured at the time, date and place, an	nd due to the cause(s	s) and manner as st	ated. cause(s) and manner stated
	thin 2	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowled 29b. Signature and title of certifier	ge, death occurred at the time, date and place 29c. License number	ce, and due to the cau	use(s) and manner as	stated.
	F ≥ F Z		MD .	00064788		. Date signed (Mont	25th 2011
J	. \ . /			D: "			
0×	\ \		VIJAY SHARMA 821 N EUINWS	I SUITE 301 BALT	TIMORE M	10 51501	
	Star Registra	ie ar	31. Date filed (Month, Day, Year) OCT 2 5 2011 32. Registrar's Signman	J SUITE 301 BALT			

			Please Type o	or Print in Black	Indelible Ink. Ensure	Al Copies A	re Legible.
			1 - State Registrar		Indelible Ink. Ensure ading Phys. 6921 1 epartment of Health and certificate of Death	Mental Hygiei	
F	Physicia	n/	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death
Mary	Medic Examin	al	Walter 4a. Facility Name (if not institution, give street and not institution)	umber)	Bv1995 4b. City Town, or Location of Deat	Detaber	Day Year 22 JOII 0525 AM 4c. County of Death
may and	Funeral		The Johns Hookin 5. Social Security Number 6. Sel	3 Hospita 7. Age (In yrs. last birthda	KALTMAR & Under 1 Year I If Under 24 Hrs	8. Date of Birth	n/a g. Birthplace (State or Foreign
	Director		214-52-7259 Usual Residence of Decedent		Months Days Hours Min.	Dec. 11,	1950 Maryland
	Maryland Ba-f shov tified at	Director	10a. State 10b. County Maryland Frederick	10c. City, Town or	Location nrovia		10d. Inside City Limits 1 ☐ Yes 2 😿 No
	with the I s 23a or 2 ust be no	Funeral Di	10e. Street and Number 12300 Rosswood Drive	2	10f. Zip Code 21770		Citizen of What Country?
980	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	Armed	s 2 XXNo Give	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 Yes 2 No Specify: Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	ithin 72 hour ene. • than "natu the Medical	Completed		(G) (G (1-4 or 5+)	ocedent's Usual Occupation five kind of work done during most of wo. five NOT use retired)	rking	US Postal Service
Maryland 2	should be filed with and Mental Hygin I smarked other traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, eve	o l	12th 17. Father's Name (First, Middle, Last) Walter M. Briggs		Supervisor 18. Mother's Na Mart	me (First, Middle, Maid	
Man	d 2 shoul		19a. Informant's Name/Relationship (Type, Print) Deborah Briggs Wife		ailing Address (Street and Number or Ru 2300 Rosswood Driv		_
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other to		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	om State 20b. Place of Di cemetery, C	sposition (Name of crematory or other place) arroll Crematory O	ct. 24, 20	s. Location - City or Town, State 11 Winfield, MD
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	4	22. Name and Address of Facility Burrier-Queen Fune 1212 W. Old Libert	ral Home	& Crematory, PA
•	Physician/		23a. Part 1 Enter the disease, or complications the shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition	at caused the death. Do not each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
المهر	Medical Examiner	,	Due Due	to (or as a consequence of):	rdial infarction	1	
	ecuted and -transit	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	o (or as a consequence oi).			
00	te be execut nysician and he burial-trar	ш	resulting in death) Last Due	to (or as a consequence of):			
Box 68760	or Attending Physician: The law requires that the death certificate be exenter death. Director: After this certificate has been signed by the attending physician a Director, the funeral director, page 2 should be detached for use as the burial in by the funeral director, page 2.	Physician/Medical	in the past 12 months?		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ls, P.O.	requires that the der been signed by the s should be detached	by	Part II. Other significant conditions contributing to	death but not resulting in the	ne underlying cause given in Part I.		co use contribute to the cause of death? 2 X No 3 → CODEDIY 4 □ Unknown
Division of Vital Records,	sician: The law rec s certificate has bee director, page 2 sho	Completed				24a. Was an autopsy performed	
/ital	sician: s certific director,		25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1	XÎnpatient 2 ☐ ER/Outpa	26. Place of Death (Che		e 6 Other (Specify)
of \	Jing Phys n. After this funeral di		27. Manner of Death 1 Natural 5 Pending 28a. Da (M	te of injury 28b. Time onth, Day, Year) 28b. Time injury	e of 28c. Injury at work?	28d. Describe how in	
Division	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certificate:		ce of Injury - At home, farm, Iding, etc. (Specify)		28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
_	To the Hospital within 24 hours a To the Funeral C completely filled	Medical	(Check only one) 2 Medical Examiner: On the I	pasis of examination and/or in	th occurred at the time, date and place, vestigation, in my opinion, death occurred dge, death occurred at the time, date and	at the time, date and pl	lace, and due to the cause(s) and manner stated.
	To t To t		29b. Signature and title of certifier They It (Here)	~ mo	29c. License number	29d.	Date signed (Month, Day, Year) Ctober 22 3011
DV	,		30. Name and address of person who completed co	ause of death (Item 23a) (Typ	e, Print) N. 1. 10 1 Pa Ctn	eet B	altimone, Md 21287
	Stat Registra			negiepar's Signature	heiles		III I'm bu C IIIG BIOBI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Oct. 22, 2011 Raymond C. Burleigh /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Randallstown Chapel Hill Nursing Home If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Dec. 21, 1916 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 → M 2 □ F Dec. 070-09-9270 94 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 27s and injury or other traumatic event. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2√ No Director Carroll Westminster Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21157 2214 Cherokee Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Machinist Worthington Pump 2 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond C. Burleigh Roseltha Prior မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2214 Cherokee Drive Westminster, MD 21157 Joanne Correll Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State South Carroll Crematory Dec. 24, 2011 Winfield, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, PA 21. Signature of Funeral Service Licensee 1212 W. Old Liberty Road Winfield, MD 21784 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sevile **Physician** demente years /Medical Examiner iptial or Attending Physician: The law requires that the death certificate be executed outs after death. He death. It is certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

		Due to (or as a consequence or).	
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):	
dical Exar	that initiated events resulting in death) Last	Due to (or as a consequence of):	
by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	. Out 114 0 February 2 February	te of delivery onth Day Y
	Part II. Other significant conditions con	ntributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use cont 1 ☐ Yes 2 ☑ No	ribute to the cause of do
Completed		autopsy performed?	Were autopsy findings a prior to completion of ca death? 1 □Yes 2 □No
Be	25. Was case referred to medical examiner?	26. Place of Death (Check onty one)	<u>.</u>
	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Oth	ner (Specify)
ation:1	27. Manner of Death 11 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 \(\text{Yes} \) 28d. Describe how injury occur	red
Certification: To	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State)	oer or Rural Route Num.
ical	29a. Certifier 1 ← Certifying Phy. (Check only 2 ← Medical Exami	sician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and m iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place,	anner as stated. and due to the cause(s

	23d. Date of delivery Month Day Year
	o use contribute to the cause of death? 2-12 No 3 Probably 4 Unknown
24a. Was an autopsy performed? 1 □ Yes 2€	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No
(Check onty one)	
e 5 Residence	6 ☐ Other (Specify)
d. Describe how in	jury occurred

29b. Signature and title of certifier 30. Name and address of person who compl Thell MD

31. Date filed (Month

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MD

037573

Battimos

October 21,5011

21209

use of death (Item 23a) (Type, Print)

2835 egistral's Signature

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER ° 9,2011 5:55A Margaret S. Barnard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** June 2 1921 Hours Min. Months North Dakota Yrs Director 474-16-2790 90 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director notified 28a-f 1 Yes 2 XNo MD Baltimore Timonium 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 404 Rockfleet Rd. #201 21093 USA death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ X o 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ö Examir δ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: white Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Herman Sponheim Sophie Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Rockfleet Rd. #201, Timonium, MD 21093 John Barnard, Jr. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/20/11 Atlantic Crematory Glen Burnie, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Funeral Service Michael J. F4agle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death ACUTE MYOCARDIAL INFARCTION Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Year 4 Pregnant Pregnant at time of death sate has been signed by the a page 2 should be detached 1 ☐ Yes ∠ ≱ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 After this certificate 25. Was case referred to medical examiner? Be funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ၉ 1 ☐ Yes 2 X No 1 Inpatient 2X ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred XNatural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director: A 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifig 0

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

parker

and address of person who completed cause of death (Item 23a) (Type, Print)

KHOSROW TABASSI, M.D. 7601 OSLER DRIVE TOWSON, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene State Amend Items 22,25 per fh,me,g920,10/21/2011dhb Certificate of Death 33810 . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 745 Willie Bonner BC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Social Security Number 16. Sax NA Baltimore If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 11-23-47 1 🛣 M 2 🗆 F 63 Months Hours Min. ΜD 219-50-7191 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location notified at Director XXYes 2 No MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n 5 Funeral 21133 USA 8802 Maplebrooke Road items and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status the Medical Examiner Armed Forces? Black, White, etc. African ö ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates SpecifAmerican 'natural", 3 Widowed 4X Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 11th Grade College (1-4 or 5+) NARyland Homes Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Willie Smith Bonner Louise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3422 Barry Paul Road Randallstown, Lisa Bonner Banks-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

Bayview Crematory 1 Burial 2 Cremation 3 Removal from State 8/11/11 Balt., MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service to ensee Harry P. Close Funeral Services, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode drying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylician/ 2 hours intracranial nemorrhug Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of). ROVED BY MEDICAL EXAMINER signed by the attending physician and deed be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical CERTIFICA death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No this certificate has ral director, page 2 1 Yes 2 No 25. Was case referred to medical furieral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

Coilean E.

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22. Registrar's Signature

HOILE

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Baltimore, MD

			for Amend Ite State Registrar	State of Ma m 25 per me,	ryland / g920,1	Depar 0/21/ Certii	ment of F 2011dhb icate of L	lealth an Death	d Mental H	ygiene Reg. Na.	011	33811
	Physicia	ın/	1. Decedent's Name (First, Middle	•					2. Date of D	eath Dav	Year	3. Time of Death
M	Medic	al	Milton T. 3 4a. Facility Name (if not institution,			Ι,	011 T	1	Sip	15	2011	1:35 AM
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	Funeral Director		5. Social Security Number 213–14–8460		(In yrs. last bii 94		Under 1 Year onths Days	If Under 24 I Hours N	Hrs. 8. Date of E lin. (Month, L Jan 8	irth Day, Year) 191	Coun	place (State or Foreign htry) yland
	nd how at	ž	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Locat	on				1	10d. Inside City Limits
	/larylar Ba-f s tified	Funeral Director	MD		Balt	imore						1 ¥ Yes 2 □ No
	the Na or 2	Ϊ́	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Cour	ntry?
	h with ns 23, must	nera	2540 McCullough					1217			USA_	
21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	Completed by Fu	 11. Marital Status 1 □ Never Married 2 □ Marr 3 ☒ Widowed 4 □ Divorced 	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🔀 I If Yes, Give Year or Dates.	ver in U.S. No	If Ye	Decedent of Hi s, specify Cuba	n, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)		14. Race - Americ Black, White, Specify: bla	etc.
5-0	2 hou "natu edical	plet		t's Education st grade completed)	168		's Usual Occup		working	16b. Kii	nd of Business In	dustry
121	thin thai	S E	Elementary/Seconday (0-12)	College (1-4 or 5-	+)	life. DO N	OT use retired)	g			civil se	
	ed v Hyg othe	Be	17. Father's Name (First, Middle, L			Togi	stician 	18. Mother's	Name (First, Middl			itvice
/Jan	d be fill dental rrked o	မ	Samuel Milton	Brown					sie Thom		,	
, Maryland	id 2 should be file valth and Mental I n 27 is marked o er traumatic eve		19a. Informant's Name/Relationsh Betty Brown/da						Rural Route Numi			
Baltimore,	nit. Page 1 and sartment of Heal sortant; If item; injury or other		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S		20b. Place cemete		on (Name of ory or other plac	re)	Date	20c. Lo	cation - City or To	own, State
Balt	permit. Page Department Important: any injury o once.		21. Signati S rv e	The state of the s	ctor	1	ame and Addres ate Ana ltimore		oard 655	W. Ba	1timore	Street
	Pnysician/ Medical Examiner		23a. Part 1 Enter the disease, or shock or heart failure. List o Immediate Cabse (Final disease or condition resulting in death)	complications that caused nly one cause on each line. a. A. Due to (or as a	the death. Do			g, such as card	diac or respiratory			Approximate Interval Between Onset and Death
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	be executed sician and burial-transi	Еха	that initiated events resulting in death) Last	c. Due to (or as a	consequence	of):		0	PROVED BY MECH	AL EXAMIN	ER .	
90	te be a nysicia ne bur	dica		d				- THEICATION	PAKONED RI III			
387	rtifical ing ph e as th	Me	IF FEMALE:					EKIHOW				
. Box 68760	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 🔲 Fetal dea		ctopic pregnand ther (specify)	ey		. 2	23d. Date of deliv Month	ery Day Year
ds, P.O.	law requires that the nas been signed by the s 2 should be detach	ρ	Part II. Other significant conditio	ns contributing to death bu	nt not resulting	in the und	erlyin g cause giv	ven in Part I.				he cause of death?
	The law ate has page 2	Completed							pe	s an opsy formed?	prior to co death?	psy findings available impletion of cause of 2 No
ta	ician: The certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:		140			Check only one)			
fΝ	Physi this c	<u>ا</u>	1 XYes 2 10 No	1 ☑ Inpatie	nt 2 ER/C	Outpatient Time of	DOA Othe	4 L Nursir	ng Home 5 Re			/)
n 0	ding th. After fune	cate	1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident Investig	g (Month, Day,	Year)	injury	work	γαι ? Yes 2∐ No	28d. Describe	now injury	occurred	
Divísio	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate i completed filled in by the funeral director, pag	Certificate:	3 Suicide 6 Could in 4 Homicide determine	not be 28e Place of Injur		arm, street		755 2 3 710	28f. Location	(Street and own, State)	Number or Rura	l Route Number,
	the Hospit in 24 hour he Funers ipleted fille	Medical	(Check 2 L Medical E	Physician: To the best of r xaminer: On the basis of ex Nume Prantioner To the L	amination and/	or investiga	tion, in my opinic	on, death occur	red at the time, date	and place,	and due to the ca	use(s) and manner stated.
	To t with To t		29b. Signature and title of certifier	Relima 11	11) P	GY1	29c. License	343	7	09/	e signed (Month,	oli
1			30. Name and address of person v	HIMAN M	0,51	(Type, Prin	s hosp	sital,9	oo Cator	Ave	Baltime	ove, still
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registra	's Signature	,	4					
DHN	//H 17 Rev 7/20		OCI 3 1 50	HI Serem	B. 13		-					

ME

		1	State of Maryland	•	rtment of H tificate of D			ene 201		33812
			Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Death		V	3. Time of Death
	Physicia Medic		GLORIA LOUISE BURNER				October	^{Day} 21,	^{Year} 2011	9:55 P ^M
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or			4c. County		
			8689 Pinetree Road		Jessup	If Under 24 Hrs.	O Date of Dist	Howa		lace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y		Count	ry)
			220-30-0518 1 □ M 2 XX 80 Usual Residence of Decedent	Yrs.			July 20	, 1931		yland —————
	shov d at	tor	10a. State 10b. County 10c. City,	Town or Loc	ation				10	Od. Inside City Limits
	Mary 28a-f otifie	<u>-</u> =		ssup	T					1 Yes 2 XXIO
	th the 3a or t be n	al D	10e. Street and Number		10f. Zip Code		10	og. Citizen of W		try ?
	ath wi	Funeral	8689 Pinetree Road 11. Marital Status 12. Was Decedent Ever in U.S.	13. V	20794 Vas Decedent of His	spanic Origin? (Spe	cify Yes or No-		e - America	an Indian,
(0	within 72 hours after death with the Maryland gient ethen "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	by F	1 Never Married 2 Married 1 Yes 2 No	l li	Yes, specify Cubar	i, Mexican, Puerto	Rican, etc.)		k, White, e	
803	ırsaft u ral ", İExal	be	3 XIXVidowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	Yes 2 XX No	Specify:		Specify:	Whi	te
2-0	2 hou "nati edica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupa kind of work done di O NOT use retired)	ition uring most of work	ing 1	6b. Kind of Bu	siness/Inc	dustry
121	ithin 7 ene. • than	Con	Elementary/Secondary (0-12) College (1-4 or 5+) Grade 6		dress			I.T.S.	I.	
d 2	ਰ ੇ£ ਵ	0	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, Ma	aiden Surname	.)	
ılan	d be fi /ental irked tic ev	욘	Ernest Perry			Arline	Senay			
lan	should and N is ma		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street a					
≥,	of and 2 should be file of Health and Mental H fitem 27 is marked or rother traumatic ever		Robert Burner, Jr. / son		ghtingale		hepherds	town, V		
lore	ge 1 and the strategy of the s		1 Burial 2XXCremation 3 Removal from State	metery, cren	sition (Name of natory or other place 21 Cremato	3)	· · ·	Odentor	-	
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of I Important: If ite any injury or ot	- 4	4 ☐ Donation 5 ☐ Other (Specify) W • F			- ;			i, Ma	<u> </u>
Ba	Depart Impo		/M00770	$\frac{1}{3}$	Name and Address Oonaldson 13 Talbot	Funeral t Avenue	Home, P. Laurel	A. , Mary	Land	20707
		П	23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	er the mode of dying	g, such as cardiac	or respiratory arres	st,		Approximate Interval Between
	'mysician/	8 69	Immediate Cause (Final Chronic Obsidisease or condition	struct	ive Pulm	onary Dis	ease		_	Onset and Death Year
	Medical Examiner		resulting in death) Due to (or as a conseque	nce of):						
		e	Sequentially list conditions, if any, leading to immediate Due to (or as a conseque	ence of):					\rightarrow	<u> </u>
	ted Insit	i E	cause. Enter Underlying Cause (Disease or injury							
	execution and ial-tra	Ĕ	that initiated events resulting in death) Last C. Due to (or as a conseque	ence of):						
09	ate be executed hysician and the burial-transit	dical Examine	d							
876	eath certificate attending pho d for use as th		IF FEMALE:							
Box 687	tth cer ttendi for us	ian/	23b. Was decedent pregnant in the past 12 months? 1 Ves 2 X 6 23c. If yes, outcome of pregnant 1 Live Birth 2 Fetal 4 Pregnant at time of deal 1 Live Birth 2 Fetal 4 Pregnant at time of deal 1 Live Birth 2 Fetal 4 Pregnant at time of deal 1 Live Birth 2 Fetal 4 Pregnant at time of deal 1 Live Birth 2 Fetal 4 Pregnant at time of deal 1 Live Birth 2 Fetal 4 Pregnant at time of deal 2 Fetal 4 Pregna	death 3	Ectopic pregnanc Other (specify)	у			ite of delivi onth	ery Day Year
B.	r the a	Physician/Me	1 Yes 2 A No 9 Unknown	SAUT O'L						
P.O.	requires that the des been signed by the s should be detached	by Pt	Part II. Other significant conditions contributing to death but not resu	lting in the u	underlying cause giv	ren in Part I.	23e. Did tob	acco use cont	ribute to th	ne cause of death?
JS, I	uires l in sign	ed b					1 □ Ye	es 2 No	3 🗌 Pro	bably XIX Unknown
Records,	w req Is bee 2 sho	Completed					24a. Was ar autops	v	prior to co	psy findings available impletion of cause of
Rec	The law	Som					perform	ned? XIX No	death?	2 XX No
tal	sician: certifica irector,	Be	25. Was case referred to medical examiner?		Oth	ace of Death (Chec				
of Vital	Physi this o	2	1 Yes 2 Land 1 Inpatient 2 L	R/Outpatie 28b. Time o	nt 3 L DOA	4 ☐ Nursing H	ome 5 XXeside			/)
п	ding F th. After funer	cate	1 Actural 5 Pending (Month, Day, Year) 2 Accident Investigation	injury	work	? Yes 2 ☐ No	Zod. Boombo no	., ., .,		
Division	Atten er dear ector: by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, str	reet, factory, office		28f. Location (Str City or Town		er or Rura	l Route Number,
Div	tal or rs afte al Dira led in	0	building, etc. (Specify)			1	1			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowle 2 Medical Examiner: On the basis of examination	and/or inves	stigation, in my opinio	on, death occurred a	at the time, date and	d place, and du	ie to the ca	luse(s) and manner stated
	o the vithin (Ž	only one) 3 Certifying Nurse Practitioner. To the best of m	у кложіеаде	29c. License			9d. Date signe		
0	F S F O		Vi 2 Vallate não		D503	38		Octobe	er 24	, 2011
	1/		30. Name and address of person who completed cause of death (Item							01044
	70		Dr. Poblete, M.D. 11055 Litt		tuxent Pa	rkway C	olumbia,	Maryla	ind	21044
	Sta Registi		31. Date filed (Month, Day, Year) OCT 2 5 2011 January 32. Registrar's Signature of the State	ure						

		-	For State Registrar	State of Maryla		artment of I rtificate of			leg. No.	33813
201-1	17.		1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month		3. Time of Death
	ysicia Iedic		Franz Xaver I	Breit				Octobe		
	amin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town,	or Location of Death		4c. County of	Death
		÷	3 Kilglass Court	Apt. 203			rville		Balti	
Fune	eral		5. Social Security Number 6. S	ex 7. Age (In y	rs. last birthday,	Months Days		8. Date of Birth (Month, Day	/, Year)	Birthplace (State or Foreign Country)
Direc	ctor	-	218-40-0976	A 201	84 Yrs.			11/10/	/1926	Germany
and	_		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
Maryl 1 eho	78	6	MD Baltimo	250	Lutherv	d 110				1 ☐ Yes 2X No
the 1	1	Director	10e. Street and Number	JLE 1	TO CLIET A	10f. Zip Code			10g. Citizen of Wh	hal Country?
with	5	□	3 Kilglass Court	Ant 203		2109	3		USA	
IIII K I K I S - COOOO be filed within 72 hours after death with the Maryland nia! Hygiene. ed other then "netural, or iteme 23a or 28a-f ehow	9	Funeral	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.		Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-		- American Indian,
iter of	g .	교	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 No				o Rican, etc.)		, White, etc.
urs a	E	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	White
72 hc	Ica	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	edent's Usual Occu	pation during most of wor	kına	16b. Kind of Bus	iness/Industry
d within 72 hours afglene.	We	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)			
ed wi	4	Co	8	The lan or re	Self	Employe	d Carpent			ruction
d 2 should be file th and Mental Hy	0 Ven	Be	17. Father's Name (First, Middle, Last) Unk.nown					Maiden Sumame	"
should manke	atic	2					Theresi		Breit	7.0.1
2 sh and is m	raum		19a. Informant's Name/Relationship			3	t and Number or Ru			
C = 44	her t		Elli Hein / Frie			11g1ass (Ct. Apt.	203, Lut		P. MD 21093 Dity or Town, State
Pages 1 nent of H int: If ite	or of		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State		ematory or other pl				,
tant:	jury		4 X Donation 5 ☐ Other (Speci			ifts Regis				Maryland
Dallillore, permit, Pages 1 a Department of Hea Important: If item	eny injury o once.		21. Signature of Edneral Service Line	see		22. Name and Add			*	Registry
403	• 4			li-sissa shakara and sha						er, MD 21076 Approximate
Physic	ian		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.		YELOMA	ang, such as cardiac	or respiratory at	1000,	Interval Between Onset and Death 2 VEARS
/Med	ical		resulting in death)	Due to (or as a con		TCLOINT				2 70 113
Exami	iner		Cognostially list conditions	b						
n	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	saquence of).					
acute	trans	Examiner	that initiated events	c						
e exc	urial-	<u>m</u>	resulting in death) Last	Due to (or as a con	sequence of):					
cate be executed physicien and	d edi	dlcal		d						
artific ing p	e as	•	IF FEMALE:							
that the death certifuled by the attending is	or us	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	Fetal death 3	□Ectopic pregnan	су		23d. Date Mon	e of delivery oth Day Year
the a	hed	/slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify)				
hat th	detac	F.	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause o	uven in Part I.	23e. Did t	obacco use contri	ibute to the cause of death?
w requires that been signed by	ed b	þ	ANEMIA .	•		,	,	10	Yes 2 No	3 ☐ Probably 4 ☐ Unknown
nper need	hour	Completed	7111011117	O STEOMICH THE				04- 146-	245 14	Vere autopau findings available
He law	C)	ldu						24a. Was autor	psy p	Vere autopsy findings available rior to completion of cause of eath?
VICAL F ician: Th certificete	ged .							1 Yes	200 No 1	Yes 2 No
VICIAN ilcian certif	ecto	Be	25. Was case referred to medical examiner?	Hospital:				ath Check only o		
this of	a di	10	1 Yes 2 No	1 Inpatient	2 ER/Outpation 28b. Time		ther: 4 Nursing F		dence 6 \(\text{Othe} \)	
Affer Affer	funer	lon	1 Natural 5 Pending	(Month, Day Yea	(r) Injury	W	ork? □Yes 2□No	200. 50301.00	non anjury occurr	
DIVISION OF VITAL RECORDS, F.O. BOX or Attending Physician: The law requires that the death cerafier death. Director: After this certificate has been signed by the attending.	the /	Certification:	3 Suicide 6 □ Could not l	De 29a Place of Injury	At home farm s			28f. Location (Street and Number	er or Rural Route Number,
or A affer	i b	erti	4 Homicide determined	building, etc. (Sp	pecify)			City or To	wn, State)	
DIVISION OF VICAL MECONAS, F.O. BOX Of the Hospitel or Attending Physician: The law requires that the death certification 24 hours after death. To the Funerel Director: After this certificete has been signed by the attending it.	completely filled in by the funeral director, page	edical C	(Check only 2 Medical Exa	hysician: To the best of my miner: On the basis of exar						
the hin 24	mplet	Med	one)	and manner stated.						
오돌은	00	4	29b. Signature and title of certifier	017		29C. LICO	E4102		A Al- lan	21. 2011
			- AND COL	つうとい		Ill	77000		UCTO	217 4011
			29b. Signature and title of certifier 30. Name and address of person who Holly R Dahlma 31. Date filed (Month, Day, Year) 25 201	completed cause of death	(Item 23a) (Type) W Jopp	9, Print) P.4 RD-Si	VITE 210-	Lutha	rulles	MID 21093
4	Sta		31. Date filed (Month, Day, Year) QCT 2 5 201	32. Registrar's S	ig ature ha	Kel				
He	egistr	ar	AAI M G CO	· Maria						

William Bump, Ir

11-07718 Unk Unk

nk Unk	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death 20 3	3814
Bhysisian/	Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time	of Death
Physician/ Pedical Examiner	William Vern Bump, Jr. Month Day Year 235	i0 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Mercy Medical Center 4c. County of Death Baltimore	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYYY) 9. Birthplace (Months Days Hours Min.	
Director	354-60-9441 1XM 2F 45 Yrs. 12/15/1965 Country) M	aryland
ny	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inc.	side City Limits
bow a	MD Baltimore City	Yes 2 No
uth the Maryland 23a or 28a-f show any notified at once. al Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
3a or otifice	1119 Inner Circle 21225 U.S.A.	
r death with or items 23 must be no	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American India White, etc.	an, Black,
ter dea	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White	
2 hours aft "natural" Examine	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	
36 thin 72 has. than "n edical E	Elementary/Secondary (0-12) College (1-4 or 5+) 7 Carpenter Construc	tion
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	17, Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname)	C1011
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica TO Be Comple	William Vern Bump, Sr. Linda Louise Blankenship	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f aborancic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co.	de)
무 정품 은 취	Misty Bump / Daughter 231.0 Aiken Street, Baltimore, MD 21218 20a. Method of Disposition (Name of cemetery, Date 20c. Location - City or Town, S	itate
Baltimore, permit. Pages l ar Department of Hee Important: If ite	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 X ponation 5 Other Specify: Anatomy Gifts Registry 10/24/2011 Hanover, Mary	land
Baltin permit. P Departme Importar injury or	4 X Donation 5 Other Specify: Anatomy Gifts Registry IU/24/2011 Hanover, Mary 21. Signature of Funera Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry	10110
ELLE DE	7522 Connelley Dr., Ste. P, Hanover, MD	21076 eximate Interval
Physician Medical	failure. List only one cause on each line.	een Onset and Death
≟xaminer	Immediate Cause (Final disease or condition resulting in death) a Acute Al.cohol Intoxication Due to (or as a consequence of):	
	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):	
ted Insit Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated	
ted 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	events resulting in death) Last Due to (or as a consequence of): d.	
0, e be executed ysician and burial - transit	☐ AMENDED 23a,27,28a-f,per me,g920 10-26-11 sm	
760 ficate b g physi the bu	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year
). Box 6876(the death certificate by the attending phy ched for use as the b Physician/Me	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
he deat the deat hed for hed for	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause given in Part 1.	se of death?
P.O. Britant stranger of the detail	1 Yes 2 No 3 Probably 4	Unknown
of Vital Records, ag Physician: The law required this certificate has been signeral director, page 2 should be not To Be Completed	24a. Was an 24b. Were autopsy fir autopsy prior to completi	
Reco The law cate has page 2 s	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	2 No
	25. Was case referred to medical	
f Vi(Physic er this er this ral dire	examiner? 1 Ves 2 No 127. Manner of Death 28a. Date of Injury 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
ion of Vending Pheeath. Sor: After the funeral		
Division c spital or Attending tours after death. neral Director: Aff filled in by the fum Certification:	2 Accident Investigation Investigation Investigation Suicide S	
Divis Hospital or A 24 hours after Fruncral Dire tely filled in b	Suicide 6 x Could not be determined (Specify) Found: Street or Town, State) 200 East Fay Baltimore, Md.	
the Ho nin 24 h the Fu pletely		÷(s)
To To com	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day	r, Year)
	O.C.M.E. October 15, 2011	
	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State	31. Date filed (Month, Day, Year) 32. Registrar's fignatur	
Registra	THE ST C 2017 1 77, 1 A 4 72, 1600 00 00 00	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10 Month **Physician** 201 fai 9:43 Irene Morrison Baldwin Ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Harford Memorial Hospital Havre de Grace If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 249-66-8884 1 ☐ M 2 💢 F 69 South Carolina 8/11/1942 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Macical Examiner must be not find at 1 ☐Yes 2 XNo Director Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 USA 717 Earlton Rd by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Mary Polossi No If Yes, Give Year or Dates:1960–63 1 Never Married 2 Married 1 □Yes 💥 No SpecifwWhite 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mathematics Technician Civil Service 12 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be fi permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Lila Mock Oscar Morrison 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oscar Baldwin / Husband 717 Earlton Rd, Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harford Mem. Gardens 20c. Location - City or Town, State 20a. Method of Disposition Date X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/25/2011 Aberdeen 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Libensee Tarring-Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only of e cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Pulmonary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of) signed by the attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 C Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) □Yes 2X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☒No 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

6411

Baltimore, Maryland 21215-0036

Box 68760.

of Vital Records,

State Registrar 3. Some and address of person who completed cause of death (4m 23a) (Type, Print)

JOHN B AMPSON, MD 501 S. UNIC

31. Date filed (Month, Day, Year) 32. Sejetrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DV <u>Philip</u> Casamento 2011 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospita The Johns Hooking Age (In vrs. last birthday) 9. Birthplace (State or Foreign Date of Birth Funeral If Under 24 Hrs. 218-18-0446 Hours Min Director 1 🛣 M 2 🗆 F 89 Yrs. Washington DC Feb. 13,1922 Usual Residence of Decede 28a-f show 10a State 10b County 10c. City. Town or Location the Maryland notified at Director 1 Yes 2 No Maryland | Anne Arundel Linthicum 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be with t Funeral 525 Hawthorne Road 21090 United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ XYes 2 No 3altimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Westinghouse N/A Wireman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ bei Angelo Casamento Rosa Natoli other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trauonce. Jon P. Casamento/Son 17740 Foxmoor Drive, Woodbine, Maryland 21797 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Oct.23,2011 Glen Burnie, Maryland tlantic Crematory 21. Sign are of un al Service Licen 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. action ile 1328 Sulphur Spring RD., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ DEPSIS Medical resulting in death) (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Puneral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Pregnant at time of death Day signed by the aid be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Records, 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown After this certificate has been signerated and the sector, page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes Division of Vital 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 🔏 No Other: ည 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred injury X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier pletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29c, License number 29d. Date signed (Month, Day, Year) October 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Beaulieu 600 N. Wolfe St Baltimore Maryland 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 5 201 Registrar

Physicia Medi Exami

Funeral Director

Baltimore, Maryland 21215-0036	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death with the Maryland State death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit or provided illed in by the funeral director, page 2 should be detached for use as the burial-transit or permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: Page 1 and 2 should be filled within 72 hours after death with the Maryland State	e so The Source.

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ner	4a. Facility Name (if	not institution AMAR	-			_	4b. City, Town, BALT				40	c. County		/A
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To Be C	17. Father's Name		Last)			Tione	Paker	18. Mo		(First, Middle,	Maider			
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Robert W. Chamberlain, Son 510 Grandin Avenue Severna Park, MD 21 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - Ci														
	1 🗌 Burial 2 4 🔲 Donation	X Cremation	3 □ Rem Specify)	oval from Sta	ato C	emetery, cre	matory or other p ⊖matory	Inc.	İ		Ва	ltim	ore,	Maryland
	21. Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between													
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Medical	(Check	2 Medical 3 Certifyin	Examiner: g Nurse Pr	On the basis	of examination	on and/or inve	death occurred a	inion, deat	th occurred at date and plac	the time, date	and pla he caus	ce, and due(s) and m	ue to the nanner as	cause(s) and manner s
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	Dubter Residunt - Internal Medicine RES 000 10/21/1/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NUTAN/GOD SPMARITHN WOSPITHL, WCH RAVEN BWD, Baltimore 21239 31. Data filed (Month, Syntram) 32. Registrar's Strategy													
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** 0 10 2011 MARY CROSBY LUCY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Square 7. Age (In yrs. last birthday more Franklin 8. Date of Birth Month, Day 03/1//1955 Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number **Funeral** Months Days Hours Min. 1 □ M & F 56 219-70-9777 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, it e Medical Eventines must be notified at 1 ☐ Yes 2√√No Director Baltimore Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 72 hours after death with USA 21236 4527 Baker Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes A No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1XXNever Married 2 ☐ Married 1 □Yes XX No Baltimore, Maryland 21215-0036 Specify Specify: δ WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "rany injury or other traumatic event, the Meadons. Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irrene Mae Reman Jack Albert Crosby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7215 York Road Baltimore, Maryland 21212 Stephanie Eppler Case Manager 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Surial 2 Cremation 3 Removal from State Sacred Heart of Jesus 10/27/2011 Baltimore, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc gnature of Furter 15 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 5 months Immediate Cause (Final **Physician** disease or condition resulting in death) -/Medical Due to (or a a a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) certificate has been signed by the a rector, page 2 should be detached it 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 10 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 □Yes 2 🖬 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check or one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M.D. D 45390 October 10th 2011 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nin (In. D.) 9114 Philadelphia Road #208, Balfimore, MD21237 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ October 2011 9:15 p. M Mae Susan Carter Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** n/a Baltimore Joseph Richey Hospice If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral Days 1 □ M 2 🗓 F Months Hours Min. 8-14-1928 VA Director 29-20-7964 Usual Residence of Decedent 28a-f shov "natural", or items 23a or 28a-f sho 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21218 641 E. 30th Street within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: African-American 3 Nidowed 4 Divorced Completed the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry than " Elementary/Seconday (0-12) permit. Page 1 and 2 snound בא בא השביר Pepartment of Health and Mental Hygiene. Important: if item 27 is marked other than יחיי iniury or other traumatic event, the P College (1-4 or 5+) Loan Officer Maryland NationalBank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Matthew Randall Juanita Hunter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2820 Claybrooke Drive, Windsor Mill, MD 21244 Nichole Judd/Granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Metro Crematory 10-21-2011 21. Significant Fundal Force Licensee 22. Name and Address of Facility Wlie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line... Approximate Interval Between Onget and Doath Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): expired Icitalii Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi bause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 V No
9 Unknown Month Pregnant at time of death 5 Other (specify) Io the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of de Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 1 Na 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: 27. Manufer of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Natural 2 No Accident Investigation 6 Could not be within 24 hours after deat To the Funeral Director: 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Gertifying Nurse Prantioner: To the at the time date and place, and due to the a the 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 930 P Zer (oldoua tolor 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore FutureCare Sandtown-Winchester n/a 7. Age (In yrs. last birthday) If Under 1 Year If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min (Month, Day, Year, Country) **Director** 10-17-1925 Usual Residence of Decedent show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 1 No MD. N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2213 Westwood Avenue within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Decect Armed Forces? ¹ ☐ Yes 2 🎇 No 14 Race - American Indian 11. Marital Status Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ▼No Specify: Specify:African-American Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Balto. City Dept. of Solid Wat. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ္ Bynum Pitts Roevina Colclough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth R. Colclough/Wife 2213 Westwood Avenue, Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 Cremation 3 Removal from State 4 Donation 5/ Other (Specify) r other place) King Menorial Park 10-25-2011 Woodlawn, MD 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. Funeral Servi 21. Sign 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one ca Immediate Cause (Final Phylician ementa ascular disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) provescula Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as yes, outcome of pregnancy
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b Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 \square Pending work?
1 \(\subseteq \text{Yes} \quad 2 \subseteq \text{No} \) Accident Investigation 6 🗆 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature a le of c 29c. License number 29d. Date signed (Month. Day, Year) no completed cause of death (Item(3a) (Type, Print)

State Registrar 32. Registra

's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 23a per med cert G919 9/14/11 dk

State of Maryland / Department of Health and Mental Hygiene

State Amend Items 23aPt1,25,27,28a-f per me,g920,10/21/2011dhb

Registrar Certificate of Death

Reg. N. 2 | | 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 28 Year Car 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Ba And 9. Birthplace (State or Foreign If Under 1 Year 8 Date of Birth **Funeral** 7. Age (In vrs. last birthday. 1 ★ M 2 □ F Min Months 216-90-6047 33 0873077977 Maryland Director Yrs Usual Residence of Decedent 28a-f show 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Cumberland CO. 1 Yes 2 No NJBridgeton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 192 S. 08302 East Ave. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1X Never Married 2 Married þ Yes 2 X No Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Heating & (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than 2years Elementary/Seconday (0-12) Hygiene. HVAC Tech Air Conditioning and Mental Hygier is marked other 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other transcone. ပ္ Carrie Baker Richard Lee Carter Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 192 S. East Ave., Bridgeton, NJ 08302 Richard Sanford(Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 **Cremation 3 **D Removal from State cemetery, crematory or other place, on-site Crematory 08/19/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2) OSEPHORE OF BYOWN Jr. Funeral Home Funeral Home PA Baltimore, MD 21217 2140 N. Fulton Ave., Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Multiple Drug Intoxication (Cocaine and Opiates) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) g physician and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Physician/Medical be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Records, P.O. Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death
Unknown 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy perform death? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death filled in by the funeral 28a. Date of injury **FO**(1911) Pay, Year) **08/02/2011** 28c. Injury at work? Unknown 28b. Time of injury 28d. Describe how injury occurred 5 Pending within 24 hours after death To the Funeral Director: A **Unknown**^M Unknown Accident Investigation 6 X Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) **Unknown** 4 Homicide determined Unknown Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ehielin 31. Date filed (Month, Day, Year) OCT 2 1 2011 32. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1900 M Name (First, Middle, Last, Day 23 Month Physician/ anov o one Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Baltimore Hospital MD 21239 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex If Under 24 **Funeral** Months Min 215-18-3572 1 № M 2 🗆 F Director 9/12/1923 88 Maryland Usual Residence of Deceden or 28a-f shov 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director notified 1 ¥ Yes 2 ☐ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe 23a Funeral U.S.A. 2704 Louise Ave 21214 must death v 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. "natural", or þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 □XWidowed 4 □ Divorced Year or Dates and Mental Hygiene.
is marked other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Vending traumatic event, the Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Georgetta Brindisi Antonio Canova 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Lutherville, Maryland 21093 Antoinette V. Steigerwald/Dtr. 1405 Chippendale Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. X Burial 2 Cremation 3 Removal from State 10/29/2011 Moreland Mem Park Baltimore, Maryland 4 Donation 5 Other (Specify permit. al Servic 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 1050 York Road 23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ cerebro Vascular accident Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of). as the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Canova, To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No been signed by the a should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes completely filled in by the tuneral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 24 hours af er death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 Evasu A. Mekonen, M.D. October 23, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Boulevard Raven

Registrar

31. Date filed (Month, Day, Year)

OCT 2 5 2011

Anthony

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CONYOU 6:59 ames 100 th 09 - 2011 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charles Genesis Healthcare Center Waldorf If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) DC Months Days Hours Min. 1 🕅 M 2 🗆 F 05-04-1922 Director 579-16-7093 89 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 ☐ No MD Charles Newburg 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 20664 12398 Channel View Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. ģ 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Gov't should be filed within and Mental Hygiens is marked other th Dist. of Col. 12th DPW-laborer Be 17. Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည J. William Carroll Edna Davis permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Cromwell Dr., Oceanview, DE 19970 Carolyn Bauer/stepdaughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗓 Burial 2 🗓 Cremation 3 🗆 Removal from State 4 🗋 Donation 5 🗆 Other (Specify) Riverdale PK Crem 10-17-201 Riverdale, MD 20746 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cedar Hill FH,4111 PA Ave.,Suitland, MD kues 1401368 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner emer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) and I-transit Exami that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death signed by the a Id be detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performe After this certificate 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work' 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 71199

\0 √ State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type Print) water work of person who completed cause of death (Item 23a) (Type Print) water work of Drive IA, Annapolis, mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33824 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2011 A M Physician/ 2Î', 7:30 October Carew Dorothy Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Edenwa1d 8. Date of Birth (Month, Day, Year) April 6, 1916 g, Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) . Social Security Number 6. Sex Funeral 1 🗆 M 2 😾 F Maryland Yrs. 219-03-2573 95 **Director** Usual Residence of Decedent 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director 1 🗌 Yes 2 💢 No Timonium **Baltimore** 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral USA 21204 800 Southerly Road # 911 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore City College (1-4 or 5+) 5+ Elementary/Seconday (0-12) School System Educator/Vice Principal Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) 2 Catherine Butler William F. Carew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bel Air, MD 21014 Mary C. Tress/Neice 510 Pearwood Dr. item 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Cathedral
Cemetery 20c. Location - City or Town, State Oct. 24. 20a. Method of Disposition permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Road Timonium, MD 21093 21. Signature of Funeral Service chael J. Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Aortic stenosis Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): led by the attending physician detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant Year Month Day in the past 12 months? Pregnant at time of death Yes 2 No g 🗌 Unknown Records, P.O. is certificate has been signed by director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Heart Failure 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other: Hospital: 2 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 욘 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred filled in by the funeral Certificate: injury 5 Pending Natural 1 🗌 Yes 2 🗆 No Investigation 24 hours after death. Funeral Director: A Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сотрыется (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year) OCT 25

SUSAL

sachen

Scher CRUP 800 Southerly . Registrar's Signature

1 CRNP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R154032

Towsor

29d. Date signed (Month, Day, Year)

212860

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last 2. Date of Death Physician/ 11:46 AM Medical ne (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death Square timor lin Hospito Center Funeral 8. Date of Birth Birthplace (State or Foreign 1 M 2 F Months Hours Min. Director Isual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland City, Town or Location Funeral Director 10d. Inside City Limits 1 Yes 2 No 10g, Citizen of What Country? Was Decedent Ever in U.S. Armed Forces? 11. Marital Status . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, and 2 should e filed within 72 hours after or Health and Mental Hygiene. tem 27 is man ed other than "natural", or 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No 3 ₩ Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ injury or other traumati 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coo Department of Health Important: If item 27 lethod of Disposition 20b. Place of Disposition (Name of Surial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) permit. any inj 21. Signatur of Funer Service Licensee 1015 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dring shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Failure disease or condition ratoru Medical resulting in death) Due to (or a a consequence of): Examiner Sequentially list conditions, any, leading to infliediate cause. Enter Underlying Cause (Disease or iinjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Completed by Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month cate has been signed by the a page 2 should be detached Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requinwithin 24 hours after death.

To the Funeral Director: After this certificate has been Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 NO မ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 \(\sum \) Yes 2 \(\sum \) No 5 Pending injury Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10/33/3011 D0061667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) than MD 9000 Franklin Square Drive, Baltimore State 5 2. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ October 20, 2011 03:15P M Morris Carlin Caillouet Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Center Clinton If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months 435-42-4408 **Director** 1 **X** M 2 □ F 83 January 14, 1928 Louisiana Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d, Inside City Limits notified at Director or 28a-f 1 Yes 2X No Clinton Maryland | Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral United States 20735 10002 Paros Drive ral", or items 2 Examiner mus 1 and 2 should be filed within 72 hours after death v f Health and Mental Hygiene. item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. Armed Forces? 1946 -Black, White, etc. Completed by 1 Never Married 2 Married Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates.1951-1966 other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4 or 5+) Secret Service Senior Security Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mary Ladora Banta Louis Maurice Caillouet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn Carlin Caillouet/Son 1507 Pullman Drive, Severn, Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot Page 1 1 X Burial 2 Cremation 3 Removal from State Maryland Veterans Cemetery October 2 2011 Donation 5 Other (Specify) Crownsville, Maryland permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Will Etown 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph, sician/ disease or condition Medical resulting in death) CAIVE PULLMONARY DISAK **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine use as the burial-transi and Due to (or as a consequence of): resulting in death) Last ding physician Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) for in the past 12 months? Day Month Vear Pregnant at time of death be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown the Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform after death.

Director: After this certificate Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes ဂ္ဂ 1 X Inpatient 2 A ER/Outpatient 3 A DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work? 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Prantitioner: To 29b. Signature and title of certific

State Registrar IRENE CZERWINSKI

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	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. 2.0 3382										33827	
	_		Registrar 1. Decedent's Name (First, Middle, Last)			Cer	incate 0	Death	2. Date of Dea			3. Time of Death
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	Examin		4a. Facility Name (if not institution, give street		10	+-0	4b. City, Town	Burnie		4c. Count	ty of Death	Soundel
and the second	Funeral		5. Social Security Number 6, Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9.									hplace (State or Foreign
	Director		217-14-2681 1 M 2 K F 88 Yrs. Months Days Hours Min. (Month, Day, Year) October 8, 1923									aryland
	land show dat		10a. State 10b. County	-	10c. City	, Town or Loc	cation					10d. Inside City Limits
	• Mary • 28a-f	Director	Maryland Anne Arund	le1			Ode	nton		1 🗆 Yes 2x No		
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	eath v	Funeral	11. Marital Status 12. W	as Decedent E	ver in U.S	. 13. V		of Hispanic Origin? (Spuban, Mexican, Puerto	ecify Yes or No-	14. Ra	ace - Amer	rican Indian,
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland freath and Mental Hygiene. If health and Mental Hygiene. It has the man and Mental Hygiene are are a set of the traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 3 😾 Widowed 4 ☐ Divorced Yo	med Forces? ☐ Yes 2 Yes, Give ear or Dates.	No		Yes 2 🔀		Thous, etc.,	Specif	ack, White fy: Wh	nite
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Σ Σ	d 2 sh alth ar n 27 is er trau	11	Christine Goss/Daugh				-	ve, Westmi				
Baltimore,	le 1 and t of Heal If item 5 or other		20a. Method of Disposition 1 ☐ Burial 2 又 Cremation 3 ☐ Remo	val from State	20b. Pl	lace of Dispo	sition (Name of patory or other CArund	olace) Octo	pate ber 23,	20c. Location	ı - City or	Town, State
<u>=</u>	permit. Page 1 a Department of H Important: If ite any injury or ot once.		4 Donation 5 Other (Specify) 21. Signature of Funer Pervice Licensee	_		Cı	remator	y ; 20.				aryland
Ba	permit. Departr Importa any inji			042	MO1	386 D	onaldso	dress of Facility on Funeral napolis Roa	Home & ad. Oden	Cremato	ory, aryla	P.A. and 21113
	hysician/		23a. Part 1. En er the disease, or com lication shock, or heart failure. List only one of Immediate Cause (Final	ns that caused	the death							Approximate Interval Between Onset and Death
مر	Medical Examiner		disease or condition resulting in death)	Due to (or as	1 30	ence of):		le auto	70170			
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is, P.O	the Hospital or Attending Physician. The law requires that the death certificate be hin 24 hours after death certificate be thin 24 hours after death this certificate has been signed by the attending physici mpleted filled in by the funeral director, page 2 should be detached for use as the but the bound to be detached for use as the but the bound to be detached for use as the bound to be detached for use as the bound to be detached for the bound	þ	Part II. Other significant conditions contribu	ting to death b	out not resu	ulting in the u	inderlying caus	e given in Part I.				the cause of death?
Records,	law req has bee e 2 shou	Completed							24a. Was autop			topsy findings available completion of cause of
ž	sician: The la certificate ha irector, page 2		25. Was case referred to medical				26	6. Place of Death (Chec	1 Yes		1 🗌 Yes	2 X/No
Vita	Physician: this certificaral director, I	To Be	examiner? 1 Yes 2 No Hospit	al: 1 🔏 Inpati	ent 2 🗆	ER/Outpatier	T	Other:	ome 5 Resid	dence 6 🗆 Ot	ther (Spec	ify)
Division of	ending PP sath. or: After the ne funeral	Certificate:	1 Natural 5 Pending 2 Accident Investigation	Ba. Date of inju (Month, Da	iry y, Year)	28b. Time of injury		njury at vork? □ □ Yes 2 □ No	28d. Describe h	ow injury occu	rred	
DIVISI	al or Atters after de al Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	e. Place of Injubul building, et	ury - At ho c. (Specify)	me, farm, stre	eet, factory, offi	ce	28f. Location (S City or Tow		ber or Rui	ral Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director After this completed filled in by the funeral di	Medical	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: 0 3 Certifying Nurse Prae	n the basis of e	xamination	and/or invest	tigation, in my o	pinion, death occurred	at the time, date a	ind place, and c	due to the o	cause(s) and manner stated.
	Vith vith Con		29b. Signatule and title of certifier	OM	0		29c. Lio	ense number	44	29d. Date sign	ed (Month	n, Day, Year)
	21		30, Name and address of person who comple		leath (Item	23a) (Type, F	Print)	tal D	(n Lor	Bur	ue	MD
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registr	ar's Signat	ure						
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 33828 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Childers Betty Pauline 4:46 PM 2011 October Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b, City, Town, or Location of Death Harford Harford Memorial Hospital Havre de Grace If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Aug. 10, 1 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗶 F Min Months Days Hours Director Yrs. 033-24-4827 80 Usual Residence of Decedent or 28a-f shov im ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland rector 1 Yes 2 X No Harford Maryland Havre de Grace ٥ 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 306 Fox Road 21078 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ģ Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Decartment of Health and Mental I Imcortant: If item 27 is marked o ၉ John Raymond McRoberts Emma Aileen Haga 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21078 William Childers / Husband <u>306 Fox Road, Havre de Grace</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 10-24-11 4 Donation 5 Other (Specify) Welcome Home Baptist Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. Signature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ Amyotrophic disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): physician and the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Year ned by the a detached f 9 Unknown The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? perform 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director, to Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ပ္ 1 ☐ Inpatient 2 😾 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending Natural work? 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month) Day, Year, D0039258 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lauron Co D. White MD 615 W. Mac Phan #206 Bel An MD 2101

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2 5 2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

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of Vital

Division

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32. Registrar's Signatu

State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month plan 135 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE 7 TROJAN HORSE DRIVE PHOENIX 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Funeral 9. Birthplace (State or Foreign Sex 1 X M 2 □ F Min. Months Days Hours Country 1072371944 Director 216-44-0639 66 MD Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Examiner must be notified BALTIMORE 1 🗌 Yes 2 💢 No MD PHOENIX 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 7 TROJAN HORSE DRIVE 21131 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 X Married 1 Yes filed within 72 hours after 1 Yes 2 No Specify Completed 3 Divorced 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) f Health and Mental Hygiene.
item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) OWNER TELEPHONE Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be MICHAEL CAPLAN GOLDIE ROLL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TROJAN HORSE DRIVE, PHOENIX, MD CAROL CAPLAN/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. BETH JACOB ANSHE VESHEAR CEMETERY 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/23/2011 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Euperal Service License 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused shock, or hear failure. List only one cause on each line ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or linjury use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform this certificate 2 🗆 No 1 Yes 1 Yes 2 No or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 \sum Yes Other: ၀ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Covolus Grower 1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 5 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 33830 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Helen M. Crouthame1 Oct 2011 10:00 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carroll Hampstead Golden Crest Asst. Living If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Min. Director 217-05-1489 1 🗆 M 2 😿 F 96 Oct 3, 1915 Maryland Usual Residence of Deced 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City. Town or Location notified at Director 1 Yes 2 X No Hampstead Carrol1 MD 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral U.S.A. 21074 4019 Evergreen Avenue death 1 or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2X No Specify: Specify. "natural", Completed 3 X Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Own Home Housewife 27 is marked other r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Marie Elizabeth Kilchenstein Barber John Philip 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Owings Mills, MD f Health 20 Millgate Road Daughter Joan Grudinsky other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any injury or o once. 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 10/24/11 Parkville, Maryland ☐ Donation 5 ☐ Other (Specify) Moreland Mem Park 22. Name and Address of Facility Eline Funeral Home 21. Signatur of Funeral Service Licenses Ze 11824 Reisterstown rd Reisterstown, Md 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) the detached Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed the should be det ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 certificate 1 Yes 2 No Yes 2 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 4 □ Nursing Home 5 □ Residence 6 ☑ Other (Specify) examiner? Hospita 2 No Other: 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined Hospital Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

29b, Signature and title of certifier

31. Date filed (Month, Day, Year)

2 5 2011

completed cause of death (Item 23a) (Type, Print)

32. Registrar' Signat

ento,

29c. License number

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygier ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 1:40 AM Cirincione Benedict James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital N/A Baltimore Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** April 27 Months Days Hours Min. 220-20-3314 **Director** ,1929 Maryland Usual Residence of Decedent should be filed within (2.1.2.)
I and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-1 snowatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits Director 1XX Yes 2 □ No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 2609 Kentucky Avenue 21213 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married ρ Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Printing Company 12th. Grade Printer other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Dominic Cirincione Jenny Baranco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Mary Riley/Daughter 421 Fox Catcher Rd., Bel Air MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) of Faith Cem. 10/24/2011 Baltimore MD Gardens 22. Name and Address of Facility
Schimunek Funeral Home, Inc.
9705 Belair Rd., Baltimore MD 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disea shock, or heart failure complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, set only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Myocardia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Month Year signed by the a d be detached t Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performe death? certificate 2 PNo 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 PER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 \square Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 61966 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ollins ean 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death it 4 None Baltimore C The Johns Hopkins Hospital If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Min 176-34-6151 Director 68 1 □ M 2 **X**1**X** 04/28/1943 Pennsylvania Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director must be notified 1XX Yes 2 □ No New Jersey Cape May Wildwood ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 610 West Rio Grande Avenue 08260 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XXNo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc. 0 Completed by 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 1 Yes 2XX No Specify 3 Widowed 4 Divorced Specify. "natural" White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Own Home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o t. Page 1 and 2 should be fill tment of Health and Mental rtant: If item 27 is marked o ပ John Kottea Jean Cleary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John J Collins Jr Husband 610 West Rio Grande Avenue Wildwood New Jersey 08260 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 XX Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Cape May Co. Veterans Cem ! 10/28/2011 Middle Township, NJ Donation 5 C Other (Specify) nature of Funeral 22. Name and Address of Facility Mitchell-Wiedefefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Phylician/ METASTATIC PANCREATIC ADENOCARCINOMA disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed? Yes 2 No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ᇛ Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie MCR Res-00(

DHMH 17 Rev 06-2011

State Registrar 600 North WOIFE Street

Bultimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

MAHON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 33833 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 October 0 2:08 Judith Ann Doneski Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Halethorpe Baltimore 313 Washington Avenue 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 □ M 2 🗓 F Hours Day 2 Country) Virginia 71 212-76-0690 **Director** Usual Residence of Decedent works 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Examiner must be notified at Director or 28a-f 1 ☐ Yes 2X No Halethorpe Maryland Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 23a Page 1 and 2 should be filed within 72 hours after death with 21227 313 Washington Avenue USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. o þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White "natural", 3

Widowed 4 □ Divorced Completed Year or Dates traumatic event, the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed) during most of working and Mental Hygiene. Elementary/Seconday (0-12) 10 College (1-4 or 5+) Retail Worker Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Smith Virginia Estes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 313 Washington Avenue Halethorpe, MD 21227 Kimberly Fowler, Daughter 20a. Method of Disposition
1 ☐ Burial 2 XCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc. 10/24/11 Baltimore, Maryland 4 Donation 5 Other (Specify) permit. Signature of Funeral Service License Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ piratory disease or condition Medical resulting in death) Due to (as a consequence o **Examiner** una Cancel Sequentially list conditions, if any late cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last ne Due to lor a consequence of) sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Yes 2 No ed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to Completed by 1 🗌 Yes 2 🗌 No 3 🗍 Probably 🚛 Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 Yes 2 N within 24 hours after death.

To the Funeral Director: After this certifice completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of cert

31. Date filed (Month, Day, Year)

OCT 2 5 2011

2

(SH134 Pasadera MD 21122

d address of person who completed cause of death (Item 23a) (Type, Print

8028 Rithie Hwy

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33834 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jane Everett Devlin October 21 6:45 P. [™] Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Kingsville 12103 Glenbauer Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 062-12-2568 **Director** 1 M 2 X F 89 New York January 10, 1922 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director Maryland Baltimore Kingsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 12103 Glenbauer Court 21087 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes If Yes, Give 2X No Specify: White 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Year or Dates 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) P.R. Director St. Joseph Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eletha Adele Valin Sylvester John Holehan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4311 Arabia Avenue Baltimore Maryland 21214 Page 1 and 2 sl tment of Health a tant: If item 27 is Timothy Everett / Son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore National Cemetery 10/25/2011 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If ite any injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Maryland of Funeral Service Leonard J. Ruck, Thc. 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami attending physician and for use as the burial-transit bastnic that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 Live Sirth 2 Live Birth 2 Live in the past 12 mont Month Day Year the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to calca Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 🗌 Yes 2 No ☐ Accident ☐ Suicide Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar Signat State 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 21622 per DVR G920 10/25/11 dk

State of Maryland / Department of Health and Mental Hygiene 33835 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 7:05 P M Stephen George Delisle Sept Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Burnett Calvert Hospice House Prince Frederick If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 217-62-8515 Hours (Month, Day, Year) 59 **Director** 1**X** M 2 □ F 9/1/1952 Maryland Usual Residence of Decede or 28a-f show notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director MD Calvert Huntingtown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? I and 2 should be filed within 72 hours after death with the of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in other traumatic event, the Medical Examiner must be in Funeral 20639 3220 Juniper Lane USA 12. Was Decedent Ever in U.S. Was Decedent Armed Forces?

1 X Yes 2 No 1978 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 k No Specify: Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Tractor Trailer Owner/Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rene Charles DeLisle Myrle Prescott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3220 Juinper Lane, Huntingtown MD Renee DeLisle-Howes Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or otl cemetery, crematory or other place, 1 ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chesapeake Crem. 9/27/2011 Beltsville, MD 22. Name and Address of Facility Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee Lynda Sue Ritter M01443 per DVR 8717 Green Pastures Dr., Balto., MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician) Lymphomatous meningitis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner (Diffuse B cell lymphoma) Saque titally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examir burial-tran and Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Month ed by the a P.O. signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 schizophrenia, Hepatitis B, Hepatitis C Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? To the Hospital or Attending Physician: The law cate has ; certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director, After 1 K Natural 5 \square Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2. only one 29b. Signature and title 29c. License number D17324 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Raymon A Noble, 238 Merrimac Ct., Prince Frederick, MD OCT 2 5 20 31. Date filed (Month, State arke Registrar

Ar By

Please Type or Print in Black Indelible inko Frauxe All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Control of the Indelible in Indelible in the Indelible in the Indelible in the Indelible in Indelible in the Indelible in Indel For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:30 AM Richard J. Dabrowka 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kaltimore Baltimore Future Care Vorthpoint Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Maryland Months Days Hours Min. 8-31-1942 69 Director 214-40-1215 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Edgemere Md. Balto. 1 ☐ Yes 2 😾 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21219 Apt.107 2825 Lodge Farm Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Dabrowka Armed Forces? Black, White, etc. 1 X Never Married 2 Married Completed by White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Management Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Amelia Markiewicz Stanley T. Dabrowka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4388 Battlehill Road Brogue, Pennsylvania 17309 Carolyn Trappe Sister 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-24-2011 Glen Burnie.Md. Atlantic Crematory | 21. Signature of Funeral Service License 22. Name and Address of Facilit Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Bacterenia Physician/ disease or condition resulting in death) secks Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No ò Month Year 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 9 Unknown detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? by 05A, a-fib, COPP, page 2 should be ESRD, CHF, COPD, DM, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an depression autopsy performed? 1 Yes 2 No has death? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Holden mo 21224 Fastem 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland /		tment of H <i>ificate of L</i>			giene 0	33837	
8.	(Dhusiai	ş 3	1. Decedent's Name (First, Middle, Las	t)				2. Date of De Month	ath Day Year	3. Time of Death	
	Physici /Medic		Patricia Ann	D'Arezzo				Octobe	1 14		
100	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	ath	
3	57		Union Hospital of 5. Social Security Number 6. Social Security Number		histh day)	Elkton If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	Cecil	rthplace (State or Foreign	
	Funeral Director		1	7. Age (In yrs. last) □ M 2⊠ F		Months Days	Hours Min.	(Month, Da	y, Year) C	country)	
			214-44-8090 Usual Residence of Decedent	04				01/19	/194/ Ma	aryland	
	how		10a. State 10b. County	10c. City, To	own or Loca	ation				10d. Inside City Limits	
	e Ma	cto	VA Chester	cfield Ric	hmond					1 A Yes 2 No	
	or 28	Director	10e, Street and Number			10f. Zip Code			10g. Citizen of What C	country?	
	ath w	as l	2230 Wrens Nest 1			23235			U.S.A.		
	ltems ner de	nue	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of Hi res, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14. Race - Am Black, Wh		
36	rs aft	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【X*Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates;	1.0	Yes 22 No	Specify:		Specify: M	hite	
21215-0036	filed within 72 hours after death with the Maryland Hygiene uther then "naturel", or Items 23a or 28a-f show with the Medical Exantiver must be notified at	ted	15. Decedent's Ed	ucation 16	6a. Decede	nt's Usual Occupa	ation		16b. Kind of Business		
215	hin 7: n "n Medi	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(Give ki life. DC	nd of work done a DNOT use retired,	luring most of work)	king			
2	gient gient	Con	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Paral	egal Off	ice Mana	ger	Law		
pu	tal Hy d oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	, Maiden Sumame)		
yla	Men Men arke	မ	Joseph George	Donhauser				Patrici			
Maryland	12 sh h and h and l s m		19a. Informant's Name/Relationship (7						er, City or Town, State,		
	1 and Heatt em 2 ther t		Michael D'Arezzo			Vrens Nes		Richmon Date	od , VA 2323 20c. Location - City o		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and once.		1 Burial 2 Cremation 3	Removal from State ceme	etery, crema	tory or other place	9)				
를	artme ortani Injury		4 ☑Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	Alatta		ts Registr	y 10/2	4/2011	Hanover, N	Maryland	
Ba	Depa Impo eny Ir		1						ifts Regist P, Hanover		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death. D						Approximate	
1	Physician		Immediate Cause (Final				Renal			Interval Between Onset and Death	
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**	Examiner		On a section to the line of the section of	b							
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	nd trans	Examin	that initiated events	c							
8760,	icate be executed physician and s the burial-transit	S	resulting in death) Last	Due to (or as a consequence	ce of):						
876	cate b	dlcal		d						-	
9 ×		by Physician/Me	IF FEMALE:	23c. If yes, outcome of pregnancy					2012 11		
Bo	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	ath 3□E	ctopic pregnancy Other (specify)			23d. Date of de Month	Day Year	
o	the di y the ched	ysk	1 ☐ Yes 2 🙀 No 9 ☐ Unknown	9□ Unknown	300	Jillel (Specify)					
Division of Vital Records, P.O. Box	The law requires that the death certify the has been signed by the attending tage? should be detached for use as	y P	Part II. Other significant conditions of	ontributing to death but not resulting	g in the und	erlying cause give	on in Part I.	23e. Did t	obacco use contribute	to the cause of death?	
rds	w requires to been signer should be		DIA	BETES				10	Yes 2XNo 3□F	Probably 4 Unknown	
000	s bee	olete	H.	TN				24a. Was	an 24b. Were a	autopsy findings available completion of cause of	
R	The fav te has age 2 :	Completed				-			rmed? death?	completion of cause of	
<u>E</u>	ician: Th certificate rector, pag	4	25. Was case referred to medical				26. Place of Dear			3 2 140	
>	Physic this ce al direc	ToB	examiner? 1 Yes2 🔀 No	Hospital: 1 Inpatient 2 ☐ ER/	Outpatient	3□ DOA Othe	er: 4 🗌 Nursing Ho	ome 5 Resi	dence 6 □Other (Sp	ecify)	
0	Attending Physician: r death. ector: After this certifics by the funeral director. I	:uo	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b	b. Time of Injury	28c. Injury Work	at	28d. Describe	how injury occurred		
Sio	tendi eath. tor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be			M 101	Yes 2□No				
\leq	or At fler d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	, farm, stree	t, factory, office		28f. Location (City or To	Street and Number or I wn, State)	Rural Route Number,	
	pital ours a erat [29a. Certifier 1. Certifying Ph	veicing. To the host of my knowless	dan danth a	and at the time	o data and alaca	and due to the			
	To the Mospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical		ysician: To the best of my knowled tiner: On the basis of examination and manner stated.	and/or inve	stigation, in my op	oinion, death occur	red at the time,	date and place, and du	as stated. Le to the cause(s)	
	vithin Fo the	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Mor	nth, Day, Year)	
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7		1 1	100/		/	int)			1-1		
,		- 1	30. Name and address of person who	completed cause of death (flem 23	a/ (Type, F	11111)					
_			SHAHNAWAZ K	LITAN, 2533 AUG	USTIN	E HERMA	IN How, SU	ITEA, C	HESAPEAKE	CITY, MO 21915.	
130	Sta Registr		30. Name and address of person who of SHAHNAWAZ K 31. Date filed (Month Pay Year) 000 2 5 201	HAN, 2533 AUG	1957IN	E HERMA	AN HWY, SU	ITEA, C	HESAPEHKE	CITY, MD 21915.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33838 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year 1120 AM ROLAND EL.LSWORTH ENGLISH CICTOBER Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A SAINT AGNES BALTIMORE HOSPITA If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) **Funeral** Month, Day You Maryland 1 ▼ M 2 □ F Months Days Hours 90 Yrs. Jan. 1921 Director 219-07-0157 Usual Residence of Decedent or 28a-f show e notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🔀 No Catonsville Maryland Baltimore 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 21228 States 709 Maiden Choice Lane, RG-6104 United ral", or items? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 √2 Yes 2 □ No If Yes, Give 1942 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White Specify: "natural", 3 Widowed 4 Divorced Year or Dates 1945 f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) School System Teacher 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill the fil 2 Roland Ellsworth English Genevieve Agnes Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Jones / Daughter Ardenwood Drive, Sykesville, Maryland 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 10/22/2011 Baltimore, Maryland Signature of Euneral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ MYOCARDIAL INFARLTIEN Medical resulting in death) Due to (or as a consequence of): Examiner UNKNOWN) ARTERY DISFASE CORONARY Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to or as a consequence of Cause (Disease or linjury MASSEM HYPERTENSION that initiated events resulting in death) Last and Due to (or as a consequence of) the attending physician Physician/Medical The law requires that the death certificate be IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months? page 2 should be detached for Month Day Year Pregnant at time of death 2 No Yes 1 ☐ Yes 2 ☐ Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by STROKE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has perform certificate 2 🗌 No Yes 2 No 1 Yes Vital or Attending Physician: To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tyes ٩ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 - Natural Division 1 🗌 Yes 2 🗌 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the P 29b. Signature and title of certifie 29c. License numbe MD D70718 2011 OCTORY A 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar DARK

31. Date filed (Month, Day, Year)

MENUE

SOUTH CATON

32. Registrar's Signature

21229

MARYLAND

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Cabell Evans Oct. 2011 6:15 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7628 Old Battle Grove Road Baltimore Co. Dunda1k 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Months 214-50-5092 Hours **Director** 1 XM 2 F June 25, 1946 Maryland 65 Usual Residence of Dece 28a-f shov 10a. State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director Dunda1k Maryland Baltimore 1 Yes 2 XNo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7628 Old Battle Grove Road United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. or p Armed Forces 1 ☐ Yes 2 🗷 No If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", 3 Widowed XX Divorced Completed White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4 or 5+) Tow Truck Driver Towing 12 Years and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Annie L. Palmer Cabell W. Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 53208-2790 4146 West Martin Dr. #4 Milwaukee, WI and 2 s Health Mr. Eugene Evans (Son) or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o rematory or other place) Service Corp. 10/22/2011 Towson, Maryland 6 Other (Specify) Duda-Ruck Funeral Home of Dundalk, Maryland 21222 7922 Wise Ave. Dundalk Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical Box 68760 as use yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Month Day Year P.O. þ been signed by should be deta Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Records, 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has b performe Yes 2 No 1 Yes 2 Ko Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending ours after death. neral Director: Aff filled in by the fu 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Letritrying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 21,2011 1)30555 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

32. Registra 's Signature

7566 NIGHT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3 3 8 4 0 State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 **Physician** Thierry Georges Raymond English 18, October 5:35 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8626 Oakleigh Road Baltimore Parkville 12011 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year II Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□ F 212-62-5830 59 Director June 30, 1952 Loiret, France 18/101 Usual Residence of Decedent 10c. City. Town or Location. 10d. Inside City Limits 28e-f ehow traumatic event, the Madical Examiner must be notified at Maryland Parkville Baltimore 1 ☐Yes 2 No Director English 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? United States ò 8626 Oakleigh Road or Iteme 23a 21234 of America Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: 1 Yes 2XXVo Specify: Specify: white 3 ☐ Widowed 4 Divorced 2 "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) 0 e filed within 7. at Hygiene. Cinema Elementary/Secondary (0-12) College (1-4or 5+) George Movie Theater Technician Entertainment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fund Mental h f Health and Menta item 27 is marked George Raymond English Marcelle Dubois 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Lee English Ramm/cousin 8626 Gambier Harbour Pasadena, Maryland 21122 other October 23, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Peges 1
Depertment of H
Important: if ite
any injury or ot
once. cemetery, crematory or other place) Evans Funeral 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 5 Other (Specify) 4 Donation Forest Hill, Maryland Chapel- BelAir If Fyeral Service Doense 21. Signatur 22. Name and Address of Facility P.A. Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Arterio sclero tic **Physician** Cardio /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending physicien end for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.O. signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? certificete has b irector, page 2 si 24a. Was an autopsy of Vital 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) ٩ 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined

Attending Physicien: Division 24 hours after death. the filled in by ō Hospital completely within 24 the

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State Registrar

Medical

who completed cause of death (Item 23a) (Type, Print)

31. Date liled (Month, Day, Year) 2 5 2011

3 Suicide

29a Certifie

4 | Homicide

(Check only

29b. Signature and title of certifier

Hillot. Lutherville, Md 2109 ? 6 (vimble 32. Registrar's Signature

DHMH 17 Rev 1/2001

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)

28I. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) october 18,2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 22 2011 Year 5:06 P. M George S. Erlbeck Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Broadmead Retirement Community Cockevsville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** ^{Year)}1924 July 20, 1**XX**M 2 □ F Months 217-20-0211 87 Yrs. Director Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County oortant: If Item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Maryland Baltimore Cockeysville 1 Yes 2 WNo 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? United States Funeral 13801 York Rd. Apt. R16 21030 of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married δ 21215-0036 white 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) filed within self employed Optometrist Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental I ည India Slacum William S. Erlbeck Page 1 and 2 should be iment of Health and Ments ant: If item 27 is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 19a. Informant's Name/Relationship (Type, Print) Apt. R16 Cockeysville, Maryland Mrs. Georgia L. Erlbeck/ wife 13801 York Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 26 permit. Page 1 Department of Important: If it any injury or o once. More Tand Memorial 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Parkville, Maryland Park Cemterv of Funeral Service Licensee 22. Name and Address of Facilities Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. | art 1 | Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregna
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown sate has been signed by page 2 should be detact Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate Yes 2 No 2 🗆 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 [] No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) eral Director; After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate; 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined within 24 hours a To the Funeral D Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 25

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	Physicia		Decedent's Name (First, Middle, Last) LAURA ELLEN BOSLEY EDWARI)S			2. Date of Death		3. Time of Death 2250 M	
	Medic Examin		4a. Facility Name (if not institution, give street and number) Season's Hospice at Northwes	Location of Death	Death 4c. County of Death					
4	Funeral Director		5. Social Security Number 219-34-0176 Usual Residence of Decedent 6. Sex 1 \square M 2 $ mathbb{X} $ F 7. Age (In yrs. la	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Mar 30,	Year) Co	irthplace (State or Foreign ountry) aryland			
	aryland a-f show fied at	Director	10a. State 10b. County 10c. City	y, Town or Lo	cation /sville				10d. Inside City Limits 1 ☐ Yes 2 🔀 No	
	/ith the Ma 23a or 28 st be noti	eral Dire	10e. Street and Number 300 B Wellingborough Way	OUCKE	10f. Zip Code 210)30	1	0g. Citizen of What C		
9800	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Merital Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates.		Was Decedent of Hir f Yes, specify Cubar 1 ☐ Yes 2 💢 No	n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi Specify:		
21215-0036	2 should be filed within 72 hours aft. It and Mental Hyglene. 27 is marked other than "natural", traumatic event, the Medical Exat	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give life. D	dent's Usual Occupa kind of work done d O NOT use retired) ales Cler	uring most of wo	rking	16b. Kind of Business Retail Store	•	
Maryland	d be filed Mental Hy Irked oth tic event	To Be	17. Father's Name (First, Middle, Last) Jake Bosley		į	18. Mother's Nar Zola	me (First, Middle, M	laiden Surname) Burche	tt	
	and 2 should Health and N tem 27 is me other trauma		19a. Informant's Name/Relationship (Type, Print) Roy M. Edwards (Son)					City or Town, State, Z keysville		
Baltimore,	ermit. Page 1 and 2: epartment of Health mportant. If item 27 ny injury or other tr nce.		1 X Burial 2 Cremation 3 Removal from State	emetery, crer	osition (Name of matory or other place Mem Garde	ns 10/	Date 28/2011	Bel Air,		
Balt	ermit. Pag erartmer important eny injury ence.		21. Signature of Euneral Service Lights of Awson Martin D. Lawson	3 8	TTCHELL 500 York	NEDEFEL Road, B	D FUNERAL altimore,	HOME, IN	C. 21212	
	Physician/ Medical Examiner	ər	23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on such line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of the conditions). Sequentially list conditions, b.	or respiratory arres	st,	Approximate Interval Between Special Death of Special Death of Special				
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Divi	ipital or A ours after eral Dire filled in b		4 Homicide determined building, etc. (Specify, 29a. Certifier 1 Certifying Physician: To the best of my knowledge)	City or Town	, State)					
	o the Hos ithin 24 h o the Fun ompletely	Medical	(Check 2 ☐ Medical Examiner: On the basis of examination only one) 3 ☐ Certifying Nurse Practitioner: To the best of n	n and/or invest	tigation, in my opinio	n, death occurred ne time, date and p	at the time, date and place, and due to the	d place, and due to the	e cause(s) and manner stated. as stated.	
0	To Not	<	Hay Menuffero		2004	3375		10/23	3/2011	
7			30. Name and address of person who completed cause of death (Item LATURE W. MILLET 2835 S.M. 31. Date filed (Month, Day, Year) 32. Registrar's Signat	ithete	& Sute.	203 3	aetrnox	e, MD Zi	209	
	Stat Registra		31. Date filed (Month, Day, (Year) 32 Registrar's Signat OCT 2 4 2011	1. p.	ake					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #31 Per DVR G920 10/25/2011 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 22, 2011 **Physician** MARTHA ELAINE **EVANS** 4:35P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Brightwood Baltimore Lutherville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 07/16/1916 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XX Days Hours Mary Tand 213-40-1984 95 Director Usual Residence of Decedent with the Maryland 10b. County ns 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2XXNo Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 515 Brightfield Road 21093 USA Funeral death 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White etc. Pages 1 and 2 should be filed within 72 hours after 1XXNever Married 2 Married , o. Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify þ 3 Widowed 4 Divorced White 'natural", Hygiene. other than "natura ent, the Monical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Baltimore City Ith and Mental Hygier 27 is marked other the r traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Clay Evans Helen McCabe 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
important; if item 27 is
any Injury or other trau Harry F. Page Nephew 12100 Hooper Lane Glen Arm, Maryland 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX urial 2 Cremation 3 Removal from State ☐Donation 5 ☐ Other (Specify) St John's Cemetery Hydes 10/26/2011 Hydes, Maryland 22. Name and Address of Facility Mitchell-Wiedereld Funeral Fore Inc ignature of Funeral Service Licenses 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** duanced disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 1 ☐Live birth 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month · Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 9☐Unknown signed to the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rector page 2 s autopsy Division or Vital 1□ Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2[XNo Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident ours after death.
neral Director: / 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated
2 Medical Examiner: On the basis of examination and/or investigation in my printing data. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Hame and address of person who completed cause of death (Item 23a) (Type, Print) and, butheride 32. Registrar's Si State GCI 2.4 2011 Registrar

DHMH 17 Rev 1/2001

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-	Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Birl	h I	Birthplace (State or For Country)	oreign	
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	er death or item niner m		11. Marital Status 1 ☑ Never Married 2 ☐ Married	Was Decedent Ever Armed Forces?		Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- to Rican, etc.)		e - American Indian, k, White, etc.		
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and	he filed ntal Hy ed oth	To Be	17. Father's Name (First, Middle, Last) Levar Floyd, Sr	•	ŕ			me (First, Middle, :ear Ma)		
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Baltimore,	permit. Page 1 a Department of F Important: If ite any injury or of		21. Signature of Funeral Service Licensee							1101 E. N		
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P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Completed by Physician/Medic	Part II. Other significant conditions con	ributing to death but n	ot resulting in the u	nderlying cause gi	ven in Part I.	23e. Did te	- 4	ibute to the cause of deat	th?	
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	Registra	ır	OCT 2 5 2011	mesera p.	graves							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Foster - Bowie Robbyn Marie Physician/ 0ctober 19, 2011 6:26 Рм Medical 4a. Facility Name (if not institution, give street and number)
Prince George S County Hospital Examiner 4b. City, Town, pril ocation of Death 4Printe Beorge's Social Security Number 577 – 86 – 9758 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) DC 1 🗆 M 2 🗓 F Months Days 1290471938 **Director** Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State MD ¹⁰Prince George's 10c, City, Town or Location 10d. Inside City Limits Completed by Funeral Director Blandensburg 1X☐ Yes 2 ☐ No 10e. Street and Number 5008 Townsend Way # A5 10g. Citizen of What Country? 10f. Zip Code 20710 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 ☐ XNo Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) n/a unemployed should be filed with h and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last)
Thomas Foster 18. Mother's Name History Middle, Maiden Spinemer's S ပ္ and 2 should the Health and Metern 27 is mark 19a. Informant's Name/Relationship (Type, Pr James K. Hart II 193 Majling Address (Street and Number of Rural Route Alumber City of Joyn State Zip Cookin 20710 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🗔 Removal from State Chesapeake crematory 10/26/2011 Beltsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall Mary land free ation Services 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ARRHY+H MIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of death certificate be executed that initiated events physician ar s the burial-t resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PERTENSION Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law page 2 s autopsy perform 1 Tes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No ျှ 1 🗌 Yes Other: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: At Investigation 6 Could not be filled in by the 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ A_M 0918 Fishell lustin 7511 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Cowley Short Trayma Balti more Adams . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1**X**XM 2 □ F **Director** 213-04-9021 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits aţ 10c. City. Town or Location Director notified 1 Yes 2XXNo MD Anne Arundel Pasadena 5 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? pe i items 23a oner must be Funeral United States 21122 8000 Catherine Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 0 þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2x No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) 11 Owner/Operator Towing Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Deborah A. Drummond Donald Nelson Fishell, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8000 Catherine Avenue, Pasadena, MD 21122 Ashley Fishell - wife Page 1 and 2 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State Meadowridge Mem. Park 10-25-2011 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service Licensee MMP, Inc, 7250 Wash. Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Hemorrhan disease or condition resulting in death) Intracrania Medical Due to (or as a consequence of) Examiner Head Trauma Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examir CERTIFICATION APPROVED BY MEDICAL EXAMINER -transit Ve hicle Accident Motor that initiated events Due to (or as a consequence of): resulting in death) Last physician at the burial-t Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as 1 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No jo Day Year Pregnant at time of death detached 9 Unknown 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should Were autopsy findings available prior to completion of cause of 24a. Was an has autonsy page death? 1 ☐ Yes 2 🗡 No Yes 2 No this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending injury 1 Natural 2 Accident work? 1 ☐ Yes 2 🔀 No 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun Motor Vehicle accident PM 1915 Investigation 2nu 2011 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Waterford Ru Pasadena, MD 21122 Street Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Fractioner: To the best of my increase graduate commence the time date and place, and due to the cause(s) and manner stated. (Check 29b. Signal re and title of certifier 29d. Date signed (Month. Day, Year) Oct 14, 2011 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) HIZI STOPPHER M. TRANKLIN 54 Baltimore, MD 21201 S. Greene 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

H DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gayle E. Fienman 2011 8:30 A.M October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore 310 Old Trail Social Security Number 164–24–1192 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min June 3, Year 917 1 🗆 M 2 🔀 F 94 Yrs Illinois Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore 1 🗌 Yes 2 🏻 No 10e. Street and Number 10f. Zip Code 105 Citizen of What Country? Funeral 310 Old Trail 21212 of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ρ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) al Hygiene. Elementary/Seconday (0-12) 12 Residence Homemaker Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ella Braasch Daniel Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Old Trail Baltimore, Maryland 21212 19a. Informant's Name/Relationship (Type, Print) Mr. Joel Fienman/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 27, 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 2011 Garrison, Maryland 4 ☐ Donation 5 ☐ Other (Specify) VA Cemetery 21. Signature of ral Service Lies Pencerul Address of Escitives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical director Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 4 hours after death.

uneral Director: After the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 \square Pending work 1 🗌 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сотріете (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) DU040208

Registrar DHMH 17 Rev 7/2009

State

1205

31. Date filed (Month, Day, Year)

lemes

ork

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sti

32C

32. Registrar's Signature

Box 68760

P.O.

Division of Vital

23

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22 Year Month Physician/ 9:00 AM arne la Fosler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Hedical cent Baltimare Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** oct. 23, 1926 1 M 2 X F Months Days Hours Min 214-20-2300 Maryland Yrs. Director 84 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director notified Baltimore Baltimore MD 1 Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ö must be n Funeral 21214 6611 Fair Oaks Avenue USA items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces? Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural" 3 ₩ Widowed 4 □ Divorced Completed er than "natur, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha At Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Josephine Chiofalo Andrew Rao 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4523 Wishal Drive-Baltimore, Maryland 21236 Patty Dressel-daughter 27 Department of Health Important: If item 2; any injury or other toonce. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Gardens of Faith
Cometery Burial 2 Cremation 3 Removal from State Oct.26,2011 Rosedale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final patocellular Pnysician/ disease or condition arcinoina Medical resulting in death) Due to (or as consequence of) **Examiner** Gastrointes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated second Examine Due to (or as a consecuence on Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 ending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No o Month Year Pregnant at time of death Other (specify) signed by the al Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed? Yes 2 No death? 1 Yes 2 No certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Yes 2 No 1 Npatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 ANatural 5 Pending 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the f only one 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 1659670214 MD 22 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 Britton South Battimore Grane St. MO 21201 31. Date filed (Month, Day, Year) 0CT 2 5 2011 32. Registraris Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State of Manyland / Department of Health and Mental Hygiene Registrar

State of Manyland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ JULIETTE HELEN FRIEDLAND 10:03AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MONTGOMER MONTGOMERY GENERAL OLNE . Social Security Number Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F Min. Months Days Sept. Day, Year 1923 078-18-9532 Hours. New York 88 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Numbe 10f. Zip Code Og. Citizen of What Country?
United States 20906 15115 Interlachen Drive #317 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No 2 should be filed within 72 hours after d th and Mental Hygiene. 27 is marked other than "natural", or i traumatic event, the Medical Examin Black White etc Completed by 1 Never Married 2 Married Specify: white If Yes, Give 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname)
Rose Jacobson 17. Father's Name (First, Middle, Last) ပ Isador Marks and 2 should be Health and Meter 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9408 Reach Road. Potomac. MD 20854 19a. Informant's Name/Relationship (Type, Print) 9408 Reach Road, Potomac, MD Arlene Becker, Daughter 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 09/20/11 Olney, MD 21. Signature of Foreral S Torchinsky Hebrew Funeral Home 254 Carroll St., NW. Washington, DC. 20012 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PNEUMONIA BILATERAL Medical resulting in death) Due to (or as a consequence of) Examine NAUSEA VOMITING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): DIGOXIN TAPPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant : 9 ☐ Unknown 1 ☐ Yes ∠ ų 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ATRIAL FIBRILLATION 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 🔁 Unknown PONGESTIVE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N PULMONAR 2 T No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 2 Accident
3 Suicide 2 No Investigation filled in by the 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Box 68760 Records, Division of Vital Hospital or Attending 24 hours after deat Funeral Director:

Baltimore, Maryland 21215-0036

To the I within 2

State Registrar

Medical

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

OLUYEMISI

31. Date filed (Month Day

ADEWUNMI, MD 32. Begistrar's Signature

oxellienve, MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MONTGOMERY GENERAL HOSPITAL

SEPTEMBER 17,2011

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D59418

11-0796	5
Karl Day	id Foltz II

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar Certificate of Death Reg. No.									
Physician	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year									
Medical Examine	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death									
	708 Franklin Avenue Westminster Carroll									
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State Months Days Hours Min.	or								
Director	214-13-2988 1XM 2F 38 Yrs. 05/29/1973 Country) M	D								
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c.									
E	MD Howard Columbia 1 □Yes	2 X No								
Maryland 28a-f show d at once.	MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10655 Gramercy Place, Unit 160 21044 USA									
15-0036 filed within 72 hours after death with the Maryland Hygiene. ed other than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at once a Commisted by Furneral Director	10655 Gramercy Place, Unit 160 21044 USA 11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-	look								
ath wi	Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.	iack,								
firer de										
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A S A S A)								
	6 hull O.C.M.E. October 24, 2011									
Ø/	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223									
Stat	16 31. Date filed (Month Dev, Year) 32. Redistrar's Signature									
Registra										

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				For State Registrar	State of N	nai yiai i		rtificate o				Reg. No	7111	338	351
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		and show lat	or	10a. State 10b. County	У	10c. City	y, Town or Lo	cation						10d. Inside Ci	ty Limits
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OCTOBER	Baltimore,	permit. Page 1 Department of Important: If is any injury or c		21. Signature Funeral Service	Lice see								s Regist		
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				30. Name and address of person	who completed cause o	f death (Item	n 23a) (Type,	Print)				-	1		
	_			JACKIE JONES	, CRNP 2300	DULA	NEY V	ALLEY RI). TI	MONIU	M, MD 2	2109	3		
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DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10g Per. FH G921 11/16/2011 JH State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 21^{ay}, OCT. 3:20A M 2011 Mary Green 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Baltimore Timonium Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 09-20-33 Months **Director** 219-32-9459 78 1 M 2 XF Usual Residence of Decedent 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 X No Baltimore Timoniun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2300 Dulaney Valley Road 21093 **USA** 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc.African Armed Forces? 1 Never Married 2 X Married þ 1 ☐ Yes 2 No Specify: American 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade ΝĂ Nur<u>se</u> Bluepoint N. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Burgess Daisy Williams Samuel 19a. Informant's Name/Relationship (Type, Print) Daughtet 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21217 Lynetta E. Green 2412 Francis Street Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 \square Cremation 3 \square Removal from State Woodlawn Cem. 10-27-11 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition END STAGE RENAL DISEASE Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause E. Itar Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical e Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death.
e Funeral Director. After this certificate has been signed by the attending physicis IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery Ectopic pregnancy Month Day Year Pregnant at time of death Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ▼ No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital Other: ည 1 ☐ Yes 2 😿 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical within 24 hou

To the Funer

completely fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 201 erson who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) OCT 2 5 2011 32. Registrar's Signatur State Registrar

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21,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alfred Pierce Grubb 9:25 P M October 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Somerford Place Assisted Living Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday, 8. Date of Birth **Funeral** Days (Month, Day, Year) Country) 215-10-5643 **Director** 1 XM 2 🗆 F 95 Aug. 10, 1916|Maryland Usual Residence of Decedent 28a-f show 10a. State the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Catonsville 1 Yes 2 XNo Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 United States 20 Holmehurst Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 IX Yes 2 □ No If Yes, Give Year or Dates. WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married 5 Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify "natural", 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate 6 Appraiser 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown William Grubb Rena 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Holmehurst Avenue, Catonsville, Maryland 21228 Mrs. Alva Grubb/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10/22/2011 Baltimore, Maryland Druid Ridge Cemtery Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Rd., Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final PNEUMONIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): ALZITEIMENIS DISEASE **Examiner** YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami that the death certificate be executed Cause (Disease or injury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 phy. IE FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? ģ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 \(\sum \) Yes 2 Y No မ 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signat**y**e and title of certifier 29d. Date signed (Month, Day, Year) 27394 1. rullarden MD 10/191 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NYIV James P. Richardson, 900 Caton Ave., Mailbox 198, Baltimore, MD 21229 32. Registra s Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 21:33 PM Nancy P. Gaster October 9,2011 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** N/A attimore 7. Age (In yrs. last birthday) If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months Hours °1935 **Director** 180-26-3931 76 Pennsylvania Usual Residence of Decedent show should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho: 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c City Town or Location 10d Inside City Limits Director 1 X Yes 2 □ No Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 3617 Mactavish Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3√ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Evia Latta permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic to Freeman E. Stanton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4214 Wolf Hill Drive Hampstead, MD 21074 Thomas E. Gaster, Son Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Memorial Gardens 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct 22, 2011 Marriottsville, MD Signature of Funeral Service License Thomas Gregor MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ ardiogenic Minutes disease or condition Medical resulting in death) Examiner Days to Month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Nancy Y. Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Year Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obstructive Pulmonary 1 Yes 2 No 3 Probably 4 Tunknown Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 2 1 No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Tyes Other: 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 \(\subseteq \text{Yes} 5 Pending 2 🔲 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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ima 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 23, Da 2011 6:20P MILL ICENT POOL GOODE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death Baltimore Pikesville Arden Courts Social Security Numbe If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XX Days 11/05/1921 ear) 360-16-6564 89 Illinois Director Usual Residence of Decedent filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21 Tudor Court 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 M No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ō 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes XX No "natural", 3 Widowed 4XX Divorced Specify: White Completed Year or Dates 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental ⊁ marked o ည Andrew Eugene Pool Maude Bozarth other traumatic Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s Department of Health Thomas Edgar Goode Son 903 Monkton Road Monkton, Maryland 21111 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot XX Burial 2 Cremation 3 Removal from State Dulaney Valley Mem. Grdns. 10/26/2011 Donation 5 Other (Specify) Timonium, Maryland 21093 nature of Funeral Sen 22. Name and Address of Facilityohn O. Mitchell, IV Funeral Services of Dulaney Valley 200 E. Padonia Rd Timonium, MD 21093 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) enen Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease of impury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis compileted filled in by the funeral director, page 2 should be detached for use as the burn compileted filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?, 1 Yes 2 X No Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an . Were autopsy findings available prior to completion of cause of autopsy death? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Assisted Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie lu DOOG 1194 Oct, 24, 2011

Registrar

DHMH 17 Rev 7/2009

State

Charles

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vite 4105, Touson MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Black

31. Date filed (Month

OCT 2 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #18 Per FH 9921 11/01/2011 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2011 Donald Holmes Garver, Jr. Oct. 1:30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Timonium 8. Date of Birth (Month, Day, Year) Dec. 10 1943 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours Months 1 ★ M 2 □ F Country)
MD Director Yrs. 220-42-7813 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland Director 3a or 28a-f sh t be notified a 1 Yes 2 V No Baldwin MD Baltimore 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral USA 21013 4909 Horse Hill Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces? 1

✓ Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: white Specify: 3 Divorced 4 Divorced Completed Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Howard County within Elementary/Seconday (0-12) College (1-4 or 5+) Vice President-Human Resources General Hospital Be Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Gladys Amoe Donald Holmes Garver, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 4909 Horse Hill Rd., Baldwin, MD 21013 Mary Elizabeth Garver/wife Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Highview Cemetery 10/26/11 Fallston, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licansee Lemmon Funeral Home of Dulaney Valley, Inc. Michael lagle Timonium, 10 W. Padonia Rd., Part 1. Eater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or Approximate Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULIR Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical OCTOBER Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Month Day Year 5 Other (specify) page 2 should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown ☐ Unknown P.0. byt Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Completed by ENCEPHALOPATHY ANOYIC 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has 2 🗌 No 1 Yes Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: Certificate: To 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) DONALD 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After Natural Accident 5 Pending work 1 Yes 2 No Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 A Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) JONES, CRNP 2300 DULANEY VALLEY ROAD JACKIETIMONIUM, MD 21093 31. Date filed (Me 32. Registrar's Signature State Registrar

GARVER,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Oct. Physician/ 22^{Day} 2011 7:05 P M Helen Margaret Hendershot Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Bel Air Health & Rehabilitation Ctr. Be1 Air Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Days **Director** 298-14-8806 1 - M 2 7 F 87 Feb. 8, 1924 Ohio Usual Residence of Decedent 28a-f show 10d, Inside City Limits 10c. City, Town or Location items 23a or 28a-f sho ler must be notified at 10a. State Director 1 ☐ Yes 2 🗓 No Harford Bel Air Maryland 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21014 410 East Macphail Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12 Was Decedent Ever in U.S. 14 Bace - American Indian. Was Decedent 2... Armed Forces? 1 Yes 2 No Examiner Black, White, etc. o 1 Never Married 2 Married ş Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White 3 1√2 Widowed 4 □ Divorced "natural", Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Matilda A. Lohr Walter E. Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 63 Little Creek Lane, Edgewood, Maryland 21040 item 27 James P. Hendershot/Son other 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a Method of Disposition Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. | 10/24/2011 |Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor | 22. Name and Address of Facility Cremation Society of Marylan 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final erebrovascular Disease Privalcian/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to infinediate cause. Enter Underlying Examiner Due to (or as a consequence of). Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b, Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ed by the atten detached for u in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death
Unknown 1 ☐ Yes 2 M 9 ☐ Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical Be Hospital: 2 No Other: REHAB ONTR ဂ္ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 1 Natural 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: After injury work' 5 Pending after death. Director: Aft 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) within 24 hours a

To the Funeral D

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 D 0063981 2011

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who

Benjamin Lee,

Havre de Grace, Maryland 21078

ause of death (Item 23a) (Type, Print)

Revolution St.,

32. Registrar's Signature

ompleted

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 33858 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 ear October . Catherine N. Hood 8:00 a. M Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death Examiner 4c. County of Death Genesis Multi-Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Nu **220–38–8075 Funeral** Hours December 15, 1918 **Director** 1 M 2 X F 92 0K Usual Residence of Decede 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21214 5003 Pilgrim Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. Completed 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. 77 is marked other than "1 Elementary/Secondary (0-12) College (1-4 or 5+) Grief Brothers Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Coy **Effie** Lindsay Ernest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar. Important: If item 27 is any injury or any 5003 Pilorim Road, Baltimore, MD 21214 Jerry C.Hood, Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 10/25/2011 Timonium, Maryland Dulaney Valley Memorial 5305 Harford Road 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 5305 Hartord Rodu Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications to t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Arteriosclerotic peripheral voscular disease
Due to (or as a consequence of): months - years disease or condition Medical resulting in death) **Examiner** Hyper tension years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examir burial-transi Due to (or as a consequence of) ending physician are use as the burial Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Type II Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Dementia 24a Was an has page 2 autopsy performed' Left lower extremity contracture stasis and history of cellulitis certificate 1 🗌 Yes 2 🗆 No 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 44C Nursing Home 5 - Residence 6 - Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director. After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Katural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completely filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R097104 10/24/201

DHMH 17 Rev 06-2011

Registrar

Michelle E. Kalendek, CRNP Genesis multimedical Center 7700 York Rd. Towson, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Phŷsicia	an/	Registrar 1. Decedent's Name (First, Midd							2.	Date of Deat	h	ear	3. Time of Death 0645 hrs
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			Northwest Hospital	on, give street and n	umber)	1	Randalls			Death		Baltimo		Į.
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year	If Under		8. Date of Birt	h(MM/DD/YYY	Y) 9. Bir	thplace (State or
	Director		213-92-1464	1XM 2 F		43 Yrs.	Months	Days	Hours	Min.	01/09/	/1968	Foreig	ountry) MD
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	yland n-f show t once,	횼	MD Balt 10e. Street and Number	imore Co	•		Pike		ште		110	g. Citizen of V	Vhat Cou	
	h the Maryland 3a or 28a-f sho	Director	4 Pomona We	ct Ant 7			212					U.S.A		,
	with the 18 23a is 23a	ᇛ	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13. Wa	s Decedent o	of Hispa	anic Origi	in? (Spec	ify Yes or No-	14. Rac	æ - Amer	rican Indian, Black,
	death or item nust b	Funeral	1 Never Married 2 N	Married Armed F	orces? 2 🔀 No		es, specify C			Puerto Ri	can, etc.)		ite, etc.	_
	after	by		vorced If Yes, Give Ye or Dates:			Yes 2 X			taul afa	de element	Specify 16b. Kind of E	B1	
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36	thin 72 than than edical	Completed	12th Grade	, , , , , , , , , , , , , , , , , , , ,	, , ,	dis	abled	l				N/	A	
2-0	be filed within 72 hours a ntal Hygiene. rked other than "naturs ent, the Medical Exami	Ö	17. Father's Name (First, Middle	e, Last)	_	-l <u>-</u> -		18	3. Mother's	Name (F	irst, Middle, M	faiden Surnam	ie)	
121	uld be fi Mental I marked c event,	B	Lawrence Hi			40h Mailine	Addroos //	Character	Agne	s Ha	askins	ber, City or To	un State	7 7in Code)
MD 21215-0036	and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	٩	19a. Informant's Name/Relation Agnes Evans			1.0								MD 21208
	THE PER		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·		Place of Dispos	ition (Name o	of ceme	etery,		Date	20c. Location	n - City or	r Town, State
nor	E = 5 %		1 Burial 2 Crematic		rom State	crematory or oth		toı	rv I	10/2	االعاد	 Balti	mor	e. MD
Baltimore.	permit. Page Department Important: injury or ot	1	21 Signature of Funeral Service											
ä	21 Signature of Funeral Service Licensee 22 Jame and Address of Facility Own Jr. Funeral 2140 N. Fulton Ave., Baltimore 28. Part I finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart													
	hysician Water	4	failure. List only one caus	e on each line. Sc	nizophre	enia ass	ociate	ed a	igita	ited	deluri	um dur:	Lng	Approximate Interval Between Onset and Death
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			Sequentially list conditions,	b		,								
		je j	if any, leading to immediate cause. Enter Underlying Cause		a consequence of	of):								
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Box 6876	leath certificate e attending phys for use as the b	Physician/M	23b. Was decedent pregnant in past 12 months?	the 1 Live	birth	2 Fe	tal death	3	Ectopic	pregnanc	Э	Month		Day Year
XO	eath ce attender for use	/sici	1 Yes 2 No 9 U	nknown g Unkr	nant at time of d nown	eath 5 Otl	ner (Specify,							
	ires that the de signed by the 1 be detached 1		Part II. Other significant cond	itions contributing	to death but not	resulting in the u	nderlying ca	use giv	en in Par	rt I.	23e. Did to	bacco use con	tribute to	the cause of death?
۵	res tha signed be del	d by									1 Yes	2 No	3 Pro	bably 4 🗹 Unknown
Division of Vital Records. P.O.	ysician: The law requirents this certificate has been director, page 2 should	Completed									24a. Was a autop	sy	prior to	utopsy findings available completion of cause of
Seco	The lavate has	E									1 Yes	med? 2 No	death?	'es 2 No
<u> </u>	ien: certific ctor, p	BeC	25. Was case referred to medic examiner?							Check on				
Ş	Physic or this	P	1 Yes 2 No 27. Manner of Death		Inpatient 2	ER/Outpatient			at Work?			Residence 6		ЭГ: ·
0	iding Ph h. After t e funeral	<u> </u>	1 Natural -	(Mon	th, Day, Year)	1717 h	`` ₁		s 2 X		nknown			
<u> </u>	r Atter er dear rector	licat	2 Accident Inv	estigation	ce of Injury - At h			fice bui	ilding, etc	2. 2	8f. Location (S	Street and Num	ber or R	ural Route Number, City
<u>.</u>	pital or Attencours after death oeral Director:	Certification:	Outcide	ermined (Specify) st	treet				I		tate)Kes1s Pikesvi		town Rd.& ,MD.
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b		(Oncon only	Physician: To the be										
	To the Hos within 24 h To the Fuc completely	Medical	one) 2 ✓ Medical Ex 29b. Signature and title of certi	aminer: On the basis and manner		and/or investigat			number	Juneu at [ne une, date			onth, Day, Year)
		2	255. Signature and title of certification		/_/	4		D.C.M				October 1		
200	D		30. Name and address of person	n who completed car	use of death (Iter	m 23a)	(
OF	ne		Zabiullah Ali, M.D.	Assistant Medi			Baltimore	Stree	t, Baltir	more, N	/ID 21223			
	S	tate	31. Date filed (Month, Day, Year) 32. F	Registrar's Signa	THIS COLUMN								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 23. 11:56P M 201₁ Ruth Jåne Hogan Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Brightview - Mays Chapel Ridge Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 226-26-6386 **Director** 1 □ M 2**X**□ F 88 Yrs 10/1/1923 Connecticut Usual Residence of Decede 28a-f show 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12261 Roundwood Road 21093 U.S.A. Apt 308 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home should be filed with and Mental Hygier is marked other t permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edwin T. Garrison Margaret Downey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2990 Regal Oak Drive; Manchester, MD 21102 <u>Kathleen M. Olszewski /daughterl</u> Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 \square Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem. 10/28/2011 Timonium, Maryland Ruck Towson Funeral Home, Inc. 22. Name and Address of Facility 1050 21204 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on a ch line. , such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death .Ph_sician/ 1 disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Exami Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) nding physician use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Month Day Year Pregnant at time of death No P.O. ed by the been signed be det Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy perform 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of De Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at occurred After 5 Pending Natural Accident n 24 hours after death.

e Funeral Director: At all the full of th 1 Yes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 3 29b. Signatu and title of certifier

Registrar

State

12V

death (Item 23a) (Type, Print)

gistrar's Signature

32. R

2 5 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 20b, 20c, per fh, g920, 10-25-11 sm State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:15 PM October 201 Medical 4c. County of Death Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner MACE Date of Birth 9. Birthplace (State or Foreign yrs. last birthday) 7. Age If Under 2 **Funeral** Months Min (Month, Day, Year) **Director** 1 □ M 2 🗹 F Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits notified at State Director 1 Nes 2 □ No TIMOY ritems 23a or ner must be n ò 10e, Street and Number Zip Code 10g, Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 12 14. Race - American Indian Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. Is marked other than DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Be 17. Father's Name (First, Middle, Last) me (First, Middle, Maiden Surname) Department of Health and Menta Important: If frem 27 is marked to any injury or other traumation once. Merae ပ One (Son) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ď 21 Keginala MD 20c. Location - City or Town, State

Baltimore, MD 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date cemetery crematory or other place)

Western Cemetery 4 Donation 5 Other (Specify) Funeral Service Licensee 21. Signat ineval Home, P.A. W le disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. 23a. Part 1 Enter to shock, or heat Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ yocar disease or condition Medical resulting in death) Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 \(\sum \) Yes 2 \(\sum \) No Month Day Year Pregnant at time of death Unknown signed by the at d be detached for g Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2 No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 5 Pending work? 1 🗌 Yes hours after death. 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 24 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and title of certifier October of death (Item 23a) (Type, Print) nd 2123 550/40C mo 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 21 2 0°1′1 5:05 AM Grayson Smith Holland Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON 8. Date of Birth
(Month, Day Ye 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours , 1926 Baltimore, MD Director 214-22-4344 85 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Cockeysville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21030 10535 York Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11 Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Yes 2 f Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Year or Dates, 44 -46 White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Industrial Machinery/ College (1-4 or 5+) Elementary/Seconday (0-12) Ward Machinery Computer Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ъ Method Smith Holland Grace Wurm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1995 Esther Ct. Forrest Hill, MD 21050 Carolyn Dickerson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State October 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2011 Glen Burnie, MD 21. Signature of Funeral Service 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Michael Flagle 23a. Par 1. Enter # disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ventralar Physician/ Tachycarles hour disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ears andiomyopath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that is introduced to the conditions of the con Exami Hospital or Attending Physician: The law requires that the death certificate be executed andtran that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Box 68760 as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death P.O. ed by detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed' certificate 2 🗌 No 1 Yes Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 PNo မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at After 1 Natural 5 \square Pending work?
1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Grayson

State Registrar

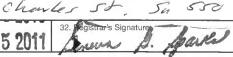
Medical

29a. Certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 29b. Signature and title of certifier



Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

00043489

Belforene

29d. Date signed (Month, Day, Year)

MB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bonny Lou Hague October 24, 201 1 1 a 9:40 Medical 4a. Facility Nai **Examiner** me (if not institution, give street and number) Breckenriage circle 4b. City, Town, or Location of Death 4c. County of Death Arundel Social Security Number 204-40-6576 . Age (In yrs. last birthday) 61 Yrs. If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** Birthplace (State or Foreign Country) 1 M 2 XF Months Days 08/047 1951 Director PA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Anne Arundel Riva 1 X Yes 2 No 10e. Street and Number 1298 Breckenridge Circle 10f. Zip Code 21140 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Richard Bowman Lorraine Orlando 19a. Informant's Name/Relationship (Type, Print) Lisa Schumacher / Daughter 1935 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20209 E. 14th Street, N Independence, MO 64056 Baltimore, 20b. Place of Disposition (Name of Chestpeaker) Cremetery 20a. Method of Disposition 20c. Location - City or Town, State Beltsville, MD 10/26/2011 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Mary I and Cremation Services
PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death
/c/2 010 Immediate Cause (Final disease or condition resulting in death) Physician/ fancreas he wro endocrine cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed led by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 menths?

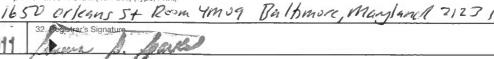
1 Yes 2 No
9 Unknown Month Day Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed cate has been signated by page 2 should by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page performed? Yes 2 No death? 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month. Day, Year) Takeru D53070

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0.05 - 2011CATHERINE McDONALD HENDERSON 2140 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death rince George's Southern Maryland Hospital Clinton Social Security Number . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 □ M 2**X**□ F Days $12^{\frac{(Month Day)^{Year)}}{19-1922}}$ 255-36-1533 Director 88 Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Prince George's Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? Funeral 20772 USA 7709 Georgian Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Force þ 1 Never Married 2 Married Maryland 21215-0036 ☐ Yes 2 X No Specify: Black 1 ☐ Yes 2X No Specify. "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry 12th Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental F Willie Mae McIntosh James McDonald, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is 7709 Georgian Dr., Upper Marlboro, MD 20772 Basil Johnson/son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Suitland, MD Cedar Hill Cem. 10-12-201 4 Donation 5 Other (Specify) Signature Funeral Service Licenses 22. Name and Address of Facility 20746 Cedar Hill FH,4111 PA Ave.,Suitland, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Therescleration disease or condition resulting in death) 3 5 eas Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of) death certificate be executed that initiated events Due to (or as a consequence of): physician ar s the burial-t resulting in death) Last Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò sign I be To the Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Vinknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? Yes 2 2 2X No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) 10-7-2011

Registrar DHMH 17 Rev 7/2009

State

P.O.

Division of Vital

11701

32. Registraris Signatu

Civingstan nd #101 fort watington MD 20 744

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.P

Sidanen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33865 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 952 AM Kiefer Oct 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City Town, or Location of Death 4c. County of Death Howard County General Hospital Howard Columbia 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
Pennsylvania 1 □ M 2**X** F (Month, Day, May 21 Months Days Hours Year Director 89 166-24-0697 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Prince George's Laurel 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 7610 Stratfield Lane 20707 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or ite Armed Forces?

1 Yes 2 X No Black, White, etc. <u>Ş</u> 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H George Chester Kiefer Clara Loretta Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other tran once. Leslie Jean Branch/Daughter 7610 Stratfield Lane, Laurel MD 20707 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 10/24/2011 Brentwood, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 20707 23a. Part v. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, of heart failure. List only one ladse on each line. Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) connestive Medical Due to (or a la consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury burial-trar that initiated events Due to (or as a consequence of): attending physician I for use as the burial Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Vear Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DRUMONIA autopsy performed' 2 1 No Yes **Division of Vital** To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) <u>_</u> 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending Accident Investigation 6 Could not be completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) Do066 Sis Oct 18 Zoll 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

5755 Cedar Lane,

Columbia, MD 21044

Nishi Rawat,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 12050110 umm October 0 2011 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death MANOR CARE RUXTON BALTIMORE TOWSON 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Min. Hours 1 □ M 2 🔀 F 10/02/1919 215-09-5483 92 MD Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits ₩ Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? CHARLES STREET, #707 3900 N. 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify Specify: 3 □ Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CATERER FOOD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **JACOB** NEUBURGER REBECCA ASCHER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SALLY MILLER/DAUGHTER 2027 MASTERS DRIVE, BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State OHEB SHALOM MEM. PK. 10/23/2011 4 ☐ Donation 5 ☐ Other (Specify) REISTERSTOWN, MD Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final menti disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner?

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be ပ

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinator resist be notified at aging.

burial-trar attending physician as the ase signed by the a d be detached f cate has been si page 2 should b certificate

P.O. Box 68760,

Division of Vital Records,

Examine law requires that the death certificate be executed director, this funeral After 1

Hospital or Attending Physician: The death. within 24 hours after death To the Funeral Director: filled in by the

Physician/Medical 2 Completed Be Certification: To

Medical

State Registrar

			£0.	i idoc oi bed	111	took only only	
spital: 1 ☐ Inpatient 2 ☐		3 🗆 DO	Other: 4	Nursing H	ome	5 Residence	6 Other
28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28	3c. Injury at Work?	2 DN-	28d.	Describe how inj	ury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State) 28f. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

(Specify)

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) Addo

and manner stated.

Но

5 Pending

investigation

6 Could not be determined

Richard 31. Date filed (Month, Day, Year) 25 2011

1 Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

32. Registrar

ellong Lane

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 900 p Margaret Ellen Hornbeck 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BAltimore WAShirston Meligal Cente Glen BUSNIC Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2 F 8/20/1924 Maryland 219-12-3413 87 **Director** Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director MD Anne Arundel Co. Severna Park 1 🗆 Yes 🚈 No 10e, Street and Number 10g. Citizen of What Country? Funeral 21146 515 Grandin Avenue United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian . or Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Transportation Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clark Fielder Crawford Lillian May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mrs. Marilyn J. Doyle/Daughter 515 Grandin Avenue Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park : 10/28/2011 Glen Burnie, MD 21. Signature of Funeral Service Lie 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave. SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Congestive Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events the attending physician and the for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 No After this certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 💢 No ျပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Matural injury 5 Pending ☐ Accident
☐ Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 21,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAltimore Washington Medical Henry FRANCIS MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

OCT 2 5 2011

MANGA COT

DIVISION OF VITAL RECORDS, P.O. BOX 68/60,	To the Hospitel or Attending Physician: The law requires that the death certificate be executed		To the Funerel Director: After this certificate has been signed by the ettending physicien and	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
DIVISION OF VITAL	lospitel or Attending Physician: T	within 24 hours after death.	unerel Director: After this certificat	ily filled in by the funeral director, po

	1 - For State Registrar	State of Ma	•	epartmei <i>Certifica</i>				giene Reg. No.2 (3386	
	Decedent's Name (First, Middle, Last	st)					2. Date of Dea	ath	V	3. Time of Dea	
an	Donald Edward	Hornia					Month Octob	er 20,	2011	4:55	
al er	4a. Fecility Name (If not institution, give			4b. City	, Town, or Lo	cation of Deat			nty of Death		
	22680 Cedar Lane	Court, #2	2204	Le	onardt	own		St.	Mary	's	
	Social Security Number 6. Security Number		e (In yrs. last birt	Months		Under 24 Hrs Hours Min.		h v. Year)	9. Birth	place (State or Fountry)	
	577-48-1757	⊠ M 2□F	75	rs.	33,0		07/11	/1936		nington,	
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Li	
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Director	MD St. Mar	ys	Leona	rdtown	ip Code			10g. Citizen o	of What Cou	intry?	
		Count III	0004							, -	
Funeral	22680 Cedar Lane	12. Was Decedent			0650	anic Origin? (S	Specify Yes or No	U.S.A. city Yes or No-			
F	1 ☐ Never Married 2 ☐ Married	Armed Forces?	•	If Yes, sp	ecify Cuban,	Mexican, Puer	to Rican, etc.)	tc.) Black, White, etc.			
by	3 ☐ Widowed 4 🖾 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 ⊠ No 3	Specify:		Specify: White			
Completed	15. Decedent's Ed	fucation	16a.	Decedent's Usi	ual Occupation	n		16b. Kind of Business/Industry			
ple	(Specify only highest gra	College (1-4or !	5+)	(Give kind of w life. DO NDT	rork done duri use retired)	ng most of wo	rking	,			
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Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)								ame)		
To	John Gustav Hornig Lunette Elizabeth Gib									son	
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2									(ip Code)	
	Crystal Ann Hornig / Daughter 37280 Tanyard Drive, Mechanicsville, MD 20										
	20a. Method of Disposition 20b. Place of Disposition (Name of Compation of Compatio									Town, State	
	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Anatomy Gifts Registry 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility Anatomy Gifts Regi										
	21. Signature of Funeral Service Licen	1500									
	1-01			7522 C	lonne11	ley Dr.	, Ste. P	, Hano	ver,	MD 21076	
L	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents.									Interval Between	
dical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.										
Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		□Ectopic pregnancy 23d. Date □ Other (specify) Mon					ivery Day Year			
ğ	Fair II. Other significant conditions	ontributing to death b	out not resulting in	the underlying	cause given	in Part I.		obacco use c Yes 2□No		the cause of death	
Completed	DINRIT	ES M	ELLITU	(24a. Was	an 24	b. Were au	itopsy findings avai	
Ĕ	77.) 40 0 1		, , , , ,			,	perfo	autopsy performed? performed?			
ŭ						6. Place of De	1 ☐ Yes	s 2. No 1 Yes 2 No			
To B	examiner?	Hospital:	ent 2 ER/Ou	trationt 3 7	Other				Other (Spa	cufu)	
		28a. Date of Inju (Month, Da	ury 28b. T	Dutpatient 3 DOA 4 Nursing Home				SHesidence 6 Other (Specify) Describe how injury occurred			
Certification;	3 Suicide 6 Could not be determined	28e. Place of In building, et	rm, street, facto	eet, factory, office 28f. Location			n (Street and Number or Rural Route Number, Town, State)				
Medical (29a. Certifier (Check conty one) 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner a content of the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner and manner stated.									to the cause(s)	
	29b. Signature and title of certifier	2	29c. License number			29d. Date signed (Month, Day, Year)					
Σ	29b. Signature and trile of certifier. 29c. License number 29d. Date signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATENDER S- 61-1 SHIM ASSOCIATES, LEWARN 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 2 5 2011					20-	- 2.1				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33869 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JOHNSON Month Physician/ DATRICIA Day 8:15 A M 2011 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PLACE FREDERICK LANCASTER FLEDERICR Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗹 F Months Days Hours Min. WASHINGTON AL 579-66-3773 62 **Director** Yrs MAYS Usual Residence of Decedent 28a-f shov 10b. County filed within 72 hours after death with the Maryland must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director FREDERICK ms FREDERICK 1 ✓ Yes 2 ☐ No o 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral PLACE 21703 519 LANCASTER USA 1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. the Medical Examiner ò þ 1- Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK "natural" Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) WRITER 12 714 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ၉ JOHNSON WARREN E. DORIS BROWN permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH WASHINGTON LANCASTER PLACE FLEDERICK MD. 21703 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) SMITHS BURG 4 Donation 5 Other (Specify) SMINGBURG CREM. 00.17,2011 21. Signature of Funeral Service Ligensee, 22. Name and Address of Facility GARY L. ROLLINS FOW. HOME Kollis saw d. 110 WEST SOUTH ST FREDERICK 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Duri to (or as a nonsequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Cause (Disease or linjury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery ō in the past 12 months? Month 1 Yes 2 To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours To the Funeral C Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature at 29c. License number 29d. Date signed (Month: Day, Year, 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JENIFER Physician/ 2011 MARIE ALICE Month 4:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DRIVE BIGNONIA AUREL PRINCE GEORGE (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 578-64-5066 1 □ M 2 Ø F Days Hours Min. 68 Months Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at **Funeral Director** MD PRINCE GEORGE LAUREL 1 Ø Yes 2 □ No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a BIGNONIA 10117 20708 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc or) δ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced Specify: BLACK Year or Dates 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) HUGHES Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. QUALITY CONTROL ELECTRONICS 12774 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 CLARKE JONES RAYMOND MARJORIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAMULE A REDDIL Jr. (SON) 10117 BIGNONIA DR. LAUREL MD. item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or otl once. → Burial 2 ☐ Cremation 3 ☐ Removal from State WEUSALOM Bot, Ch. Cem. OCT 28, 2011 POOLESVILLE MO. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CARY L. ROLLINS FOW. HOME 21. Signature of Funeral Service Licensee sand. 110 WEST SOUTH ST FREDERICK MD 21701 23a. Part 1. Ent _ thi disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): ng physician a Physician/Medical attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: asn 23b. Was decedent pregnant 23d. Date of delivery Live Birth
Pregnant
Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? this certificate has page 2 autopsy performed' 24 No Yes 2 No 1 Yes To the Hospital or America...
within 24 hours after death.

To the Funeral Director. After this certifics 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 NResidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying purse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar

Box 68760

P.0.

Records,

Division of Vital

29b. Signature and title

30. Name and address

1. Date filed (Month, Day,

25

IVAN

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD.

9200 BASIL CT.

70102

LARGO, MD. 20774

10-24-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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		1- For State Registrar		of Marylar		artment o rtificate of		nd Menta	,,,	Reg. No.		3387
Physic Medical Exam			ne (First, Middle,Las Cornell	•	on.				2. Date of De Month October	eath		3. Time of Death 1740 hrs
*		4a. Facility Name (if not institution, give	e street and num	ber)		4b. City, Town, o	or Location of D		4c. County		
Funera		5. Social Security I		ex 7	Age (In yrs. I	last birthday)	If Under 1 Ye	ear If Under 2	4Hrs. 8. Date of E	N/A		place (State or
Directo	r	215-78-		M 2 F	5	53 Yrs	Months Da	lys Hours	Min. 12/1	4/1957	Foreign Cour	ntry) MD
v any		Usual Residence of 10a. State	10b. County		10c. City,	, Town or Locati	on				1	0d. Inside City Limits
ne Maryland or 28a-f show fied at once.	į	MD 10e. Street and Nu	N/A	-		Balt	imore	·				1 Yes 2 No
the Mar a or 28	Director	1214 Wa	lker Av	∍.			10f. Zip Code	1239		10g. Citizen of Wr		y?
eath with the items 23a ust be noti	Funeral	11. Marital Status	ed 2 Married	12. Was Deced		.S. 13. Wa	Decedent of H	ispanic Origin?	(Specify Yes or N erto Rican, etc.)		- America	n Indian, Black,
after des ul", or i	Y Fu	3 Widowed	4 Divorced	1 Yes If Yes, Give Year or Dates:	2 X No		Yes 2X N		,	Specify:	Bla	ack
2 hours : "natur	Completed by	15. Decedent's Ed	ducation (Specify on	ly highest grade College (1-4		16a, Decedent during mo	's Usual Occupa ost of working lif	ation (Give kind e. DO NOT use	of work done retired)	16b. Kind of Bu		
036 vithin 7; ene. er than	m ple	8th Gra	de	College (1-4	0, 31,	ur	nemploy	yed		disab	led	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Be Co	17. Father's Name Charles							ame (First, Middle, hy Pend			
D 21; should b and Men is mar	100	19a. Informant's Na	me/Relationship (Ty					et and Number	or Rural Route Nu	mber, City or Town		
e, MI and 2. Health 3 item 27		20a. Method of Disp			20b. F	Place of Disposi	ion (Name of ce	emetery,	Date	ings Mi		MD 21117
imor Pages ment of tant: If		4 Donation 5	Cremation 3 Other Specify:	_		rematory or oth -site (ory	20/11	Baltim	ore,	, MD
Balt permit. Depart Import injury		21, Sign ture of Funeral Service Licensee 22 Name and Address of Farility own Jr. Funeral 2140 N. Fulton Ave., Baltimor										ne PA
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ox 6876 eath certificate attending phy	ian/N	23b. Was decedent p past 12 months?	regnant in the	23c. If yes, outo		2 Feta	I death 3	Ectopic pre	gnancy	23d. Date of d Month	delivery Day	Year
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Vital Rel hysician: The this certificate I director, page	æ	25. Was case referre examiner?	[Ho	spital: 1 inna	tient 2 E	ER/Outpatient		of Death (Che	ck only one)			
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Divers a filled r	Certification:	4 Homicide	6 X Could not be determined	(Specify)		d at hor		anang, oto.	or Town, S Baltimo	tate) 1214 M	Valke	r Ave
Division of Vital To the Hospital or Attending Physician: within 24 hours a er ceath. To the Funeral Director: After this certifi completely filled n by the funeral director,	Medical	29a. Certifier 1 Coneck only 2 V	ertifying Physician ledical Examiner: C	n the basis of ex	amination and	e, death occurre d/or investigation	d at the time, da n, in my opinion	ite and place, a , death occurre	nd due to the caus	e(s) and manner a and place, and due	is stated. e to the ca	iuse(s)
\$ 15 E	¥ ¥	29b. Signature and ti	a	nd manner stated			29c. License			29d. Date signed		
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rrv		Jack Titus Mi	D. Deputy Ch				ltimore Stre	et, Baltimor	e, MD 21223			
St Regist		31. Date filed (Month)	Day Year)	32. Registr	ar's Signature	Kal			·	-		

arquis Jones		Please Type or I	Print in Black In Maryland / Depa				ible.	3387
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Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	2	f Under 1 Year If Under 2 Months Days Hours	Min. 8. Date of Birth	(MM/DD/YYYY) 9. Bird Foreig	n A a s
Director		unk 1 m	2_F	Yrs.		12/19/	1992 00	untry) 1/10
any		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
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s after	Š		Dates:		s 2 No specify:		Specify:	Jack
hour fratu	ted	15. Decedent's Education (Specify only harmonic Elementary/Secondary (0-12)	College (1-4 or 5+)		Jsual Occupation (Give kind of working life. DO NOT use		16b. Kind of Business/I	ndustry
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	Be	Maurice.	Johnsi)n	To	nva.	Jones	
ID 2'should and Me 7 is ma	2	19a. Informant's Name/Relationship (Type	Print) (Mother)	19b. Mailing Ad	Idress (Street and Number	r or R ral Route Numb	er, City or Town, State	Zip Code)
E da da Z		20a. Method of Disposition	JONES I 20h P	lace of Disposition	(Name of cemetery,	Date Date	20c: Location - City or	2125 Town State
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Baltimore, permit. Pages 1 a Department of He (apportant: If ite injury or other to		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens		ay yiew	C. to the Cale Lat	0/27/11	Dundal	K, IND
Baltimo permit. Page Department o Important: injury or ott		Odinar S	a.	23	useph L	Russ Fu	neval Hom	
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Medical	ii ii	failure. Lift only one fause on each in immediate Cause (Final disease a. Mu	_{ine.} Itiple Gunshot Wound	ds				Between Onset and Death
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Box 68760, e death certificate be the attending physicied for use as the buri	sicia	1 Vos. 2 No.9 Unknown	Pregnant at time of dea	th 5 Other	(Specify)			
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	o Be	examiner? 1 ✓ Yes 2 No	ital: 1 Inpatient 2 🗹 E	ER/Outpatient 3	lou		esidence 6 Other:	
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Spital spital spital	Certification:	4 Homicide determined	(Specify) Alley			2200 Aiken Stre	eet, Baltimore, Md.	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the			To the best of my knowledge the basis of examination and					
To t with To tl	Medical	2	I manner stated.		29c. License number		29d. Date signed (Mon	
^	-	him him	2		O.C.M.E.		October 16, 2011	
7		30. Name and address of person who comp	pleted cause of death (Item 2	23a)			2, 1	
	ı		cal Examiner 900 V		Street, Baltimore, MD	21223		
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature					
Regist	rar	OCT 2.5 2011 A	. A Box	Made				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar 33873 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3:00A.M Medical Town, or Location of Death **Examiner** 4c. County of Death della Avenu 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral Director** 1 **X**M 2 □ **F** -16-1930 Usual Residence of Decedent or 28a-f show notified at Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "notice."

any injury or other trainments. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 ☐ No timore 10e. Street and Number 10g. Citizen of What Country? Funeral 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 If Yes, Give Year or Dates. 2 No 1 ☐ Yes 2 KNo Specify. 3 Widowed 4 Divorced 1ack 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Security Adm ears SOCIAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ohnson Mae Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (A 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2011 4 Donation 5 Other (Specify) Signat e of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death **Physician** disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death certificate has been signed by the lirector, page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Certificate: To 1 🗆 Yes Other: 2 No 9.24 hours after deaun.
e Funeral Director: After this referent filled in by the funeral di 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work?
1 Yes injury 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2. 3 🗆 Cactifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only or 29b. Signati Name and address who completed cause of death (Item 23a) (Type, Print)

NEL GOON Cloudes S

DHMH 17 Rev 06-2011

State Registrar Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33874 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year JEETER LOIS October 7:03 P M **Medical** 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMURE HARBOR HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months 1 🗆 M 2 🗓 F (Month, Day, Year) 08/26/1918 Days Hours Min. Director 215-01-3021 93 Usual Residence of Decedent 28a-f shov with the Maryland 10a State 10b. County Examiner must be notified at **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 No Baltimore Catonsville ō 10e. Street and Numbe 10g. Citizen of What Country? 23a 715 Maiden Choice Lane 21228 Apt. HV 302 U.S.A. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ö by Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 'natural", 3 X Widowed 4 Divorced Completed White Specify: Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene.
is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 9 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ျ Atwood Tate Della Leonard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Mr. Larry D. Jeeter / 3605 Platte Court Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park | 10/26/2011 Glen Burnie, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD RC Singleton Funeral & Cremation Services, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Acute renal failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 5 days Unnan that infection Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial I or Attending Physician: The law requires that the death certificate be a after death. Director: After this certificate has been signed by the attending physicia Physician/Medical Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No for Day Pregnant at time of death Month Year signed by the a g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate performed Yes 2 N 1 🗌 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To 2 MNo Other: 1 Tes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending filled in by the ☐ Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number MD KES GOGG October 20 2011

DHMH 17 Rev 7/2009

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Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 SOUTH

32: Registrar's Signature

GAWESH

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10 Month 2011 Thomas Kempton 01:08 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Lutherville-Timonium Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) Hours Director 070-12-8147 94 111/07/1916^{ar)} 1 🛛 M 2 🗆 F NY 28a-f shov "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8820 Walther Blvd. #1117 21234 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner many injury or other traumatic event, the Medical Examiner many. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Completed by 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Mechanical Engineer U.S. Govt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 2011 John Kempton Victoria Champlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OCTOBER 20, James Popp, Personal Representative 7 Hunters Court, Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗌 Burial 2 🔀 Cremation 3 🗍 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Svc. Corp. 10/22/2011 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Serondia 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition SEPSIS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence of for use as the burial-transi Cause (Disease or injury that initiated events nding physician and resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregno 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Hospital or Attending Physician: The law requires that the death Day Pregnant at time of death Month Year been signed by the a should be detached g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 CUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has it hin 24 hours after death.

the Funeral Director, After this certificate I
mpletely filled in by the funeral director, pag perform Yes 2 X No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 🗶 Natural 5 Pending injury Accident
Suicide Investigation 2 \square No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \square Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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29b. Signature and 📶

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CRNP

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Registrar DHMH 17 Rev 06-2011 2300 DULANEY VALLEY RD.

person who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

TIMONIUM, MD 21093

701

29c. License number

3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. \angle 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** illiam 19 2011 ctober /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A Johns Hopkins Bayview Medical Center Baltimore If Under 24 Hrs. Hours Min. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 1 □**X**M 2 □ F Months Davs 220-14-0488 Director May 29, 1927 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 🕅 No MD Baltimore Dunda1k 10e Street and Number 10f. Zip-Code 10g. Citizen of What Country? 5 items 23a Funeral 6 Seabright Avenue 21222 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2X No þ 3x Widowed 4 □ Divorced White 'natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Steel Industry 2 Years Supervisor marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental I Important: If item 27 is marked o any Injury or other traumatic even once. Adam Kalwa Rose Wolski ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. William A. Kalwa, Jr (Son) 5712 Carrington Drive White Marsh, Maryland21162 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) of Mary Cem. 10/22/2011 Dundalk, Maryland 4 Donation Ht. 21. Sign fu of Funeral Service Lice 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ymphomatous Yue to ras a consequence of): unknown disease or condition resulting in death) /Medical Examiner Due to (or as a consequance of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, physician and s the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Lower Gastrointestinal 2 No 3 Probably 4 Nnknown Completed Staph 24b. Were autopsy findings available prior to completion of cause of death? aureus 24a. Was an autopsy performed AS piration Preu mon 2 🗌 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Unpatient Other: 4 \sum Nursing Home 1 Tes 2 No 2 ER/Outpatient 3 DOA မ 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1'Natural Injury nours after death.

neral Director: Aff 1 Yes 2 No 2 Accident 3 Suicide Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor

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completely f Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29d, Date signed (Month, Day, Year) D69660 October 19

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State Registrar 31. Date filed (Month, Day, Year)

OCT 2 5 2011

Grand 32. Registra's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible, for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Donald James Kilroy :50 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A2904 Westfield Avenue Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. . Age (In yrs. last birthday) Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 215-28-5308 XX M 2 □ F Baltimore, 06/26/1932 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director MD N/A Baltimore 28a-f 1 Yes 2 No 10e Street and Number 10g. Citizen of What Country? U.S.A ò 10f. Zip Code must be r Funeral 21214 2904 Westfield Avenue items ? and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ö þ 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4 or 5+) Elementary/Seconday (0-12) City of Baltimore Security Guard ulth and Mental Hygie 27 is marked other r traumatic event, ti other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Inez Grace McDonald William P. Kilrov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2904 Westfield Avw Baltimore, MD 21214 Department of Health ar Important: If item 27 is any injury or other trau Joyce Kilroy 20b. Place of Disposition (Name of Garrison refetor grater place) Veterans Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 10/26/11 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. muchael 6009 Harford RD Baltimore, MD 21214 23a. Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine burial-transi Due to (or as a consequence of resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No detached for Pregnant at time of death Unknown Dav the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown peen s en upha lopaltu Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 12 10 Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred hin 24 hours after death. the Funeral Director; After Natural 5 Pending 1 Yes Investigation 6 Could not be Accident filled in by the 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 18, 2011 HILDA KLEIN 9:20 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🖁 F Months Hours 1270871918 Director 212-03-4230 Usual Residence of Decedent 28a-f show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 V No MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7 LORRE COURT 20852 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 X Widowed 4 Divorced Specify: Completed WHITE er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ SOLOMON MITNICK IDA LOOBAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 STANLEY KLEIN/SON LORRE COURT, ROCKVILLE, MD 20a. Method of Disposition
1 | A Burial 2 | Cremation 3 | Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If its
any injury or ot 10/23/2011 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Part 1. Enter to disease, or complications that caused shock, or he in failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ISCHEMIC ULCER OF LSE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or, the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use it yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work?
1 Yes 2 No 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 30. Name and address of person who completed cause of death (Item 23a) (Type Print)

Registrar

State

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5 2011

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 33879 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:43 A^{M} 2011 Medical David Lorton 10/22/ 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Davs Hours Min. (Month, Day, Year) Director 090-36-0741 Usual Residence of Decedent 1 🔀 M 2 🗆 F 66 Yrs. 3/4/1945 New York St. 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director N/A Baltimore MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 2307 Maryland Ave. USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Deceden... Armed Forces? ¹ ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A .H.D Disabled Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ew 2 Frank Lorton Rose Mahrens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Reynolds-Friend 2401 Mayfield Ave. Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 10/25/201 Baltimore, 22. Name and Address of Facility March F/H East 1101 E. North Signature of Fupera Service Licensee MD 21202 Baltiomore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death NG Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami use as the burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law , page 2 autopsy performe 2 🗆 No this certificate 1 Tyes Division of Vital in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Spec 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director; 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Scertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 21093 State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10/24 7 2011 10:40 AM Ruth Virginia Linton Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Sun Valley Assisted Living Westminster Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🔀 F Days Hours (Month, Day, Year) 6/13/1921 90 Director MD 218-64-6315 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No MD Carrol1 Mt. Airy 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 308 Buffalo Rd. 21771 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married ģ Yes 2 No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Yes, Give 3 Midowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Foodland/Foodrite 12 Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည permit. Page 1 and 2 should be: Department of Health and Ments Important: If item 27 is marked Charles P. Buckman Nora M. Gilbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Linton/Son 203 Flower Ct., Mt. Airy, MD 21771 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Prospect UMC Cemetery 10/27/2011 Mt. Airy, MD 21. Signature of Funeral Service Licenses ²²Blancard Addross of Eaglity</sup>Funeral Home & Crematory, P.A. any 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death ed by the a detached f 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed Yes 2 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Spe ASSISTEDLIN Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မှ After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1- Natural 5 Pending 24 hours after death Funeral Director; A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar westminster mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ M. Laccitello 2011 45 AM Gloria OCI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARTORD HEALTH AND REHABILITATION CENTER 8. Date of Birth 9. Birthplace (State or Foreign If Under **Funeral** 1 🗆 M 2XX Months Days Hours June 15, 1931 078-26-4235 80 New York **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified an once. 10a. State 10b, County 10d. Inside City Limits 10c, City, Town or Location Director Abingdon Maryland Harford 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21009 United States of America 2989 Harrogate Way 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify. Specify: White 3₩Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) New York Telephone Telephone Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Modafferi Jennie Giordano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2989 Harrogate Way, Abingdon, Maryland 21009 Raymond Laccitello - Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Raymonds Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Branx, New York 10/24/2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice Name and Address of Facility
Evans Funeral Chapel & Cremation Services - Parkville 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami -transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Pregnant at time of death been signed by the should be detached 1 L Yes 2 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perforn death? Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death e Hospital or Attending Pl 24 hours after death. e Funeral Director: After th 28b. Time of 28c. Injury at Certificate: Of Di Natural 28d. Describe how injury occurred injury 5 Pending 2 🗆 No 1 Tyes Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Exampher: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature 29c. License number erson who completed cause of death (Item 23a) (Type, Print) 308745455 Date filed (Month, Day, State 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore, Maryland 21215-0036		notes.
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show a say injury or other traumatic event, the Medical Examiner must be notified at one.	Funeral Director	Physicia Medic Examin
To Be Completed by Funeral Director		n/ al er

Division of Vital Records, P.O. Box 68760

1	to the mospital of Attending ritisation. The law requires that the beath certificate be executed within 24 hours after death	ا Ex
} ∨	To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	/ledica

	1 - For State of Stat	•	Certificate c	r nealth and r f Death		eg. No. 2 0 1	1 22002						
/	1. Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death						
an/ cal	ALBERT ANDREW LIBOWITZ				OCTOBE	R Day 2 201	1 6:30 AM						
ner	4a. Facility Name (if not institution, give street and number			n, or Location of Death		4c. County of Dea							
	NATIONAL INSTITUTES OF I			ESDA		MONTGOM							
	218-64-6828 1 M 2 □ F	Age (In yrs. last birth	Months Da	ear If Under 24 Hrs. ys Hours Min.	8. Date of Birth (Month, Day, 04/19/1	Year) 9. Bir Co	thplace (State or Foreign nuntry) MD						
=	Usual Residence of Decedent 10a, State 10b. County	10c, City, Town	or Location				10d. Inside City Limits						
Funeral Director	MD BALTIMORE	OUTNO	S MILLS				1 ☐ Yes 2 X No						
뺩	10e. Street and Number	OWING	10f. Zip Coo	le	11	0g. Citizen of What Co	ountry?						
la	9 STONE MARK COURT, #4		211	17		-g							
Š	11 Marital Status 12, Was Deceder	nt Ever in U.S.		L / of Hispanic Origin? (Sp uban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	IISA erican Indian,						
	1 X Never Married 2 ☐ Married 1 ☐ Yes 2	X No			Rican, etc.)	Black, Whit	e, etc.						
ed	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates		1 ☐ Yes 2 🔀	No Specify:		Specify: WH	ITE						
Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. I	Decedent's Usual Oc (Give kind of work do	cupation ne during most of work	dina .	16b. Kind of Business	Industry						
E O	Elementary/Seconday (0-12) College (1-4		life. DO NOT use reti										
Be	2		MEAT		FOODS								
9	17. Father's Name (First, Middle, Last)	T TD.	A		ne (First, Middle, M.	•							
ľ	JEROME 19a. Informant's Name/Relationship (Type, Print)		OWITZ	GLORIA			HEN						
			,	eet and Number or Rur			· · · · · ·						
	ROBERT LIBOWITZ/BROTHER 20a. Method of Disposition		Disposition (Name of	S LANE, #H		20c. Location - City or							
	1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from Sta	te cemetery	y, crematory or other	olace)		ŕ	·						
	4 Donation 5 Other (Specify) BALTIMORE HEBREW CONG 10/23/2011 BALTIMORI 21. Spharfure of Funeral Safvice of Survival Address of Facility SOL LEVINSON & BROS.												
	22. Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD, PIKESVILLE												
	23a. Part 1. Enter the disease, or complications that cause	ed the death. Do no					Approximate						
	23a. Part 1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each immediate Cause (Final			Interval Between Onset and Death									
	disease or condition	Metastatiz bladder concer Onset and Death 14 year.											
	Due to (or a	s a consequence of	17.										
Вē	Sequer tally list our ditions, if any, leading to immediate cause. Enter Underlying	s a consequence of	f):										
Examiner	Cause. Enter Underlying Cause (Disease or iinjury that initiated events c												
<u> </u>	resulting in death) Last Due to (or a	s a consequence of):											
Medical	d												
ğ	IF FEMALE:												
ian/	23b. Was decedent pregnant 23c. If yes, outcor	n 2 - Fetal death				23d. Date of de Month	elivery Day Year						
Completed by Physician/N	1 Yes 2 No 4 Pregnar 9 Unknown 9 Unknown	t at time of death	5 ☐ Other (specify)		INOILLI	Day lear						
<u>></u>	Part II. Other significant conditions contributing to deat	but not resulting in	the underlying caus	given in Part I.	23e. Did toba	acco use contribute to	the cause of death?						
l p	1				1 □ Ye	s 2 X No 3 □ F	Probably 4 🗆 Unknown						
Set					24a. Was an	24b. Were au	topsy findings available completion of cause of						
E					autopsy perform	ped? death?	s 2 No						
BeC	25. Was case referred to medical		26	. Place of Death (Chec	1 Yes 2	NO TO TE	5 2 110						
9	examiner? 1 Yes 2 No Hospital: 1 Inp	atient 2 - ER/Out	patient 3 DOA	Other: 4 Nursing H	ome 5 🗆 Resider	nce 6 🗆 Other (Spec	cify)						
27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work?													
2 Accident Investigation M 1 Yes 2 No													
Cert	4 Homicide determined 28e. Place of	njury - At home, farr etc. <i>(Specify)</i>	m, street, factory, offi	be	28f. Location (Stre City or Town,	eet and Number or Ru State)	iral Route Number,						
Medical Certificate:	29a. Certifier 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of	examination and/or	investigation, in my o	pinion, death occurred a	t the time, date and	place, and due to the	cause(s) and manner stated.						
Σ	only one) 3 Certifying Nurse Practioner: To t 29b. Signature and title of certifier	e best of my knowle		t the time, date and pla ense number		cause(s) and manner as							
	> Transpeathin M	OPAD		0070435	28	10/>1/20/							
	30. Name and address of person who completed cause o					1-1-1/20/	<u>'</u>						
	KIAN HUAT LIM		10 CE	NTER DRIVE	, BETHESI	DA, MARYLA	ND 20892						
te ar	31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	arle										

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Vletz 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death BWMC Pournie Anne Anundel MD Gilen Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Hours October 10, 1951 New York 60 **Director** 105-44-8419 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1100 Marley Creek Drive U.S.A. 21060 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married XYes 1 ☐ Yes 2 No Specify: If Yes, Give 1970s Year or Dates 3 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Route Sales Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ಲ Gus Metz Elizabeth Prawel 19a. Informant's Name/Relationship (Type, Print)
Susan Metz wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1100 Marley Creek Drive Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Oct 25, 2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Polyniak Funeral Home P.A. Signature onki 3204 Mountain Road Pasadena, Maryland 21122 Approximate
Interval Between
Onset and Death
In the Live of the control of the co 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Month Year 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertensis 1 Yes 2 No 3 Probably 4 Unknown Hu per choles 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie

State Registrar Name and address of person who completed cause of death (Item 23a) (Type

32. Registrar's Signature

31. Date filed (Month, Day, Year)

OCT 2 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Amend Item Registrar	State of Ma s 24a,25 per	aryland / dr.,g9	Depa 20,	rtment of 1 0/25/201 iticate of 1	lealth and I dhb Je <i>ath</i>	d Mental Hy	ygiene	0011	00001
			Registrar 1. Decedent's Name (First, Middle			0011	inouto or E	Julia	2. Date of D	eath	2011	3. Time of Death
	Physicia Medic		Roy C. Metzler						Och be	Day	2011	1717 PM
	Examin		4a. Facility Name (if not institution, Saint Agues	give street and number)	-		4b. City, Town, or	Location of De			County of Deat	h
	Funeral Director		5. Social Security Number 217–50–1376	6. Sex 1 ↑ M 2 ☐ F	(In yrs. last bir	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours N	Irs. 8. Date of B lin. (Month D Jan 7,	irth ^{Pay,} 1 ^{Year} 7	9. Bir Mai	thplace (State or Foreign Lyland
	show at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	ation					10d. Inside City Limits
	Maryla 28a-f	Director	MD		Bal	timo	re					1 🔀 Yes 2 □ No
	h the		10e. Street and Number				10f. Zip Code	2122		10g. Citi	izen of What Co	ountry?
	ath wil	Funeral	3330 Wilkens A	Avenue 12. Was Decedent E	ver in ILS	13 W		21229	(Specify Yes or No)-	USA 14. Race - Ame	rican Indian
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 X Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?		If	Yes, specify Cubar	n, Mexican, Pu	erto Rican, etc.)		Black, White	
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Mar	2 shouth and it is in the traum	10	19a. Informant's Name/Relationsh		- 1	,	,		Rural Route Numb			
ē,	f Heali item 2 other		Loretta Shaney 20a. Method of Disposition		20b. Place	of Dispos	ition (Name of		Date		ocation - City or	
Baltimore,	t. Page rtment o rtant: If rjury or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☒ Other (S	pecify) in state	cemete		atory or other plac					
Bal	permi Depar Impo any ir		21. Signature of Foneral Service J	Wade Dire	et 6/g/		Nee andrace altimore,		rd 655 W 1201	. Bal	timore ——	Street
ج مد مريد	Physician/ Medical Examiner	iner	23a. Part 1. Inter the disease, or shock, o seart failure. List o Immediate Cause I m disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Uros Due to (or as a	epsis consequence	of):	the mode of dying	g, such as card	liac or respiratory a	arrest,		Approximate Interval Between Onset and Death
09	cate be executed physician and s the burial-transit	edical Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	consequence	of):						
Division of Vital Records, P.O. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth : 4 Pregnant at 9 Unknown	2 🗌 Fetal deat		Ectopic pregnanc Other (specify)	у			23d. Date of de Month	livery Day Year
ls, P.O	uires that the signed by the detailed be detailed by the detailed by the detailed by the detailed by the signed by	ed by Pl	Part II. Other significant condition				derlying cause giv	en in Part I.				the cause of death? Probably 4 Unknown
Recórc	The law requate has been page 2 shou	Somplet	End-stage rens Congestive heart	failure					24a. Wa aut per 1 🗌 Yes	opsy formed?	prior to	ntopsy findings available completion of cause of
ta	cian: certifica ector,	Be	25. Was case referred to medical examiner?	Hospital:			Othe		Check only one)			
<u> </u>	Physi rthis o	일	1 Yes 2 No 27. Manner_of Death	1 Inpatie	nt 2 ER/O y 28b.	utpatient Time of	3 DOA Othe	4 ☐ Nursir	g Home 5 Res			cify)
on c	nding ath. r: After re fune	icate	1 Natural 5 ☐ Pendin 2 ☐ AccidentInvestig	g (Month, Day,	Year)	injury	work			, now injury	occurred	
Division	al or Atte s after de I Directo d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could (4 ☐ Homicide determi			arm, stre	et, factory, office			(Street and own, State)		ral Route Number,
_	le Hospitt n 24 hours le Funera bleted fille	Medical	(Check 2 Medical E	Physician: To the best of r xaminer: On the basis of ex Nurse Practioner: To the b	my knowledge, camination and/ pest of my know	, death or or investi- vledge, de	ccured at the time, gation, in my opinic eath occurred at the	date and place n, death occur e time, date and	e, and due to the or red at the time, date I place, and due to	cause(s) an and place, the cause(s	d manner as sta , and due to the and manner as	ated. cause(s) and manner stated. stated.
	Voithin Comp		29b. Signature and title of certifier	I MD			29c. License	number		29d. Dat	te signed (Mont	h, Day, Year)
			30. Name and address of person v	who completed cause of de	eath (Item 23a)	(Type, Pr	Caton Av	enue	Baltimor	e, N	1D Z1Z	29
	Stat Registra	re	31. Date filed (Month, Day, Year) OCT 2 5	32 Registra	r's Signature	bar	Ked		Palitime, date to Balifumor			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month October 21, Physician/ Year 2011 9:25 AM Eugene Lawrence Mulligan Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Lutherville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year Mar 02, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min Hours 86 099-24-2764 New York Director 1 **X** M 2 □ F 1925 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director MD Harford Bel Air 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 128 W. Ring Factory Rd. Apt. 1310 21014 United States death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? 1 Yes 2 No 1 Yes, Give Black White etc. by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 ₩ Widowed 4 □ Divorced White Year or Dates. WW 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) event, the Engineer General Electric Be Department of Health and Mental Hy Important: If item 27 is marked ortany injury or other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John F. Mulligan Margaret F. Ashbridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Mulligan /Son 10407 Pot Spring Rd. Cockeysville, MD 21030 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Oct 22 1 🔲 Burial 2 💆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Cremation and Funeral Alternatives helde 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition CONGESTIVE HEART FAILURE Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed?

1 Yes 2 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: ၉ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICE 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c, Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 24 hours after deatle Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🕱 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 2011 30. Name and andres f person who completed cause of death (Item 23a) (Type, Print) JONES, 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State

Registrar

31. Date filed (Month, Day, Year)

25

a.m.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 33886 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 01081 201 ORG Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** n/a Sinai Hospital <u>Baltimore</u> If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🛣 F **Director** 217-54-3128 9-21**-**1937 SC 74 Yrs. Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at Director Baltimore Yes 2 No n/a MO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21215 2712 Spaulding Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceus.
Armed Forces?
Ves 2 XNo 12. Was Decedent Ever in U.S. 14. Race - American Indian "natural", or item ledical Examiner r Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates Specify Specify: African-American 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry th and Mental Hygiene.
It is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) NSA Housekeeper Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fili Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve မ Flossie Prince Luther Kennedy Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 433 Random Road, Baltimore, MD 21229 Gloria McDowell/ Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 10/22/2011 Baltimore, Maryland by Myrie Fineral Home P.A. of Balto. Co. 4 Donation 5 Other (Specify) King Park 22. Name and Address of Facility Wile Fitner 1. 9200 Liberty Road, Randallstown, MD 21133 Sign 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or es a consequence of) **Examiner** Eague tially not our cliffure, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and the burial-trai Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy berformed? Yes 2 No certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 🗌 Yes 28d. Describe how injury occurred Certificate: 1 Natural iniury 5 Pending 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifie

State

who completed cause of death (Item 23a) (Type, Print)

hristopher Asante McMillion Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk Unk State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 14, 2011 Medical Examiner 2011 hrs Christopher McMillon 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death 1500 29th Street Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) Birthplace (State or **Funeral** 7. Age (In yrs, last birthday) Foreign Hours Director Months 1 XM 2 F 04/01/1988 Country) MD 23 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show a notified at once. 1 Yes 2 No MD N/A Baltimore permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 N. 21229 U.S.A. Monastery Ave. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc. 1 X Never Married 2 Married Yes 2 X No Specify: Black 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 12th Grade unemployed unk 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) unk McMillon Hilda Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Brown (uncle) 21 N. Monastery Ave., Baltimore, MD21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 Burial 2 Cremation 3 Removal from State on-site Crematory 4 Donation 5 Other Specify: Baltimore, MD 21. Signiture of Funeral Service Licensee Forephodes of Brown Jr. Funeral Home PA MD 21217 2140 N.Fulton Ave., Baltimore, Physician Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval List only one cause on each line Between Onset and Medica Death a, Gunshot Wounds (2) to Neck and Back Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause: Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED attending physician or use as the burial -AMENDED or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte be detached for u 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been a funeral director, page 2 should 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other₄ DOA Nursing Home 5 Residence 6 ✔ Other. Scene 1 🗸 Yes 28a. Date of Injury FOUND: 28b. Time of Injury 8c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural Subject was shot n 24 hours after death.

Le Funeral Director: △

pletely filled in by the ft. FOUND: 1 Yes 2 V No Pending Oct 14, 2011 2001 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be or Town, State) 1500 East 29th Street, Baltimore, MD determined (Specify) Local Street 4 Momicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 뗭 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b, Signature and title of certifier 20c. License number 29d. Date signed (Month, Day, Year) 6 O.C.M.E. October 15, 2011 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day, Year)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

32. Registra 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sheila Melville Drury Physician/ 00tbber 20, 2019 11:50 Pm Medical Facility Name (if not institution, give street and number)
Keswick Multi-Care Center 4b. City, Town, or bocation of Death Ball LINOY C **Examiner** 4c. County of Death If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 228 - 44 - 2676 **Funeral** 1 □ M 2**X**□ F Months Days Hours Min 0/21/12/8/1925 England **Director** Usual Residence of Decede 10a. State 28a-f shov 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director Alexandria 1 Yes X No 10f. Zip Code 22307 10e. Street and Number items 23a or ner must be n 10g. Citizen of What Belle Funeral 1711 Haven Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married 2XXMarried Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired)

Social Elementary/Seconday (0-12) College (5-4 or 5+) Mental Worker Worker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EIISabeth Tomb and Mental F Kenneth Drury ρ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic to 19a. Informant's Name/Relationship (Type, Print)
Anne Hemmendinger/Daughter 1808 Circle Road, Towson, MD 22649 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 10/21/20 1 Burial 2 X Cremation 3 Removal from State Chesapeake" एम्सा Beltsville,, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Orota Marshall Name and Address of Facility remation Services 21203 23a. Part - Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medica 26. Place of Death (Check only one, examiner' Hospital 2 🗹 No 1 🗆 Y96 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man er of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 🗌 No Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a d title of certifier 29d. Date signed (Month, Day, Year) 00064788 MI October 21 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. EUTAW ST, SUITE 301 BACTIMORE MD 21201 VIJAY SHARINA 821 31. Date filed (Month, Day, Year)

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Registrar

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Physicia Medic		1. Decedent's Name (First, Middle, L. Gloria S. Mi	xter						2. Date of Dea October	14 ^{Day} 2011	Year	3. Time of Death
Examin	er	4a. Facility Name (if not institution, given as 3138 Remington A	,			4b. City, Town, c Balt	or Location o	of Death		4c. County	of Death /A	
Funeral Director		212-28-6647	Sex 7. Ag	e (In yrs. Ia 80	est birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, March		9. Birthi Coun Mary	place (State or Foreign tay) r Land
Maryland 28a-f show otified at	rector	Usual Residence of Decedent 10a. State 10b. County Maryland	N/A	10c. City	, Town or Loc Balt	imore					1	0d. Inside City Limits 1 XXYes 2 □ No
h with the ns 23a or 3 must be no	Funeral Director	10e. Street and Number 3138 Remington	Avenue			10f. Zip Code	21211			10g. Citizen of V	Vhat Cour SA	ntry?
ore, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The mary is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ted by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.		l I	Vas Decedent of Fires, specify Cuba	an, Mexican,	in? (Spec , Puerto R	ify Yes or No- lican, etc.)		e - Americ k, White, c Whi t	
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Completed by	15. Decedent's (Specify only highest g Elementary/Seconday (0-12)	Education rade completed) College (1-4 or 5	i+)	(Give F life, D	ent's Usual Occup ind of work done O NOT use retired) Homemaker	oation during most	of workin	g	16b. Kind of Bu	wn Hon	,
yland Ild be filed Mental Hy, larked oth	To Be	17. Father's Name (First, Middle, Last) Charles Hill					18. Mothe		(First, Middle, N	Maiden Surname,		
Mar nd 2 shou ealth and m 27 is m ner traum		19a. Informant's Name/Relationship (Theresa Burchett	Type, Print) Daughter		19b. Mailin	g Address (Street 3138 R	and Number Cemingto	r or Rural on Ave	Route Number, nue, Balt	City or Town, St Limore, M	tate, Zip C arylar	od 21211
timent crant: If		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec	rify)	CE	emetery, crem	sition (Name of latory or other plac orest VA C		.0/25/		20c. Location - Owings M	•	
Bal permi Depar Impor any ir		21. Signatur uneral Service Licer	Henss)	Bi 36	Name and Addre rgee Henss 31 Falls R	ss of Facility Seitz oad, Ba	Funer iltimo	al Home, re, Maryl	Inc. 21	1211	
Physician/ Medical	0 1	23a. Part 1. Enter the disease, or conshock, of heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused one cause on estaine a. Due to (or as a) We	1		ig, such as c		respiratory arre	st,		Approximate Interval Between Onset and Death
Examiner	iner	Sequentially list conditions,		rticu	litis		Su.		#			Weeks
760 cate be executed physician and s the burial-transit	al Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	C. Due to (or as a	conseque	ence of):	OM NEW MEN	ICM EXAMIN	_/			-	
8760 tificate be ng physic as the bu	Medical	IF FEMALE:	d		THE A	ON ATT	-/				_	
Division of Vital Records, P.O. Box 68760 for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath. The law requires that the death certificate be executed for the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 1 Pregnant at 9 Unknown	2 🗌 Fetal	cy death 3 🗌	Ectopic pregnand Other (specify)		/ "		23d. Date Mon	e of delive	ery Day Year
ords, P.O.	≥	Part II. Other significant conditions of	contributing to death bu	ut not resu	lting in the ur	derlying cause giv	ven in Part I.		23e. Did tob			e cause of death?
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State Registral DHMH 17 Rev 7/200		OCT 2 4 20	32 Registrar	s Signatul	pa	Kel						

PATIENT KNOWN AS JAMES MINNIFIELD Janto Me

		-	State Amend Item 2	State of Mary 5 per me, g9	and Dep 20,10/21 Ce	artment of H /2011dhb <i>rtificate of D</i>	leaith and i Death	viental Hyg ا	giene Reg. No. 2	011	338	390	
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	Physicia: Medic		JAMES MINNI	EFIELD				OCTOB	ER 05	Year 2011	13:23	PM	
	Examin		4a. Facility Name (if not institution, give	street and number)			Location of Death			y of Death			
			SINAI HOSPITAL				MOREC						
	Funeral Director			7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Pay May 11,		9. Birth	place (State or F htry)	unk	
	now at	۲	Usual Residence of Decedent 10a. State 10b. County	10c.	. City, Town or L	ocation					10d. Inside City	Limits	
	arylar ka-f s ified	Funeral Director			Ro1	timore					1 X Yes 2	⊇ □ No	
	or 28	吉	MD 10e. Street and Number	ļ	Dal	10f. Zip Code		T	10g. Citizen of	What Cour	ntry?		
	with i	eral	4601 Pall Mall Ro	ad			21215			US	A	_	
	items items er m	ᆵ	11. Marital Status unk	12. Was Decedent Ever in Armed Forces?	u.S. 13.	Was Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-		ce - Americ			
21215-0036	e filed within 72 hours after death with the Maryland the Hygiene. de ther than "natural", or items 28a or 28a-f show event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates.	unk	1 ☐ Yes 2 🔀 No		, , , , , , , , , ,	Specif	h.	lack		
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	d 2 sl alth a n 27 i ertra		Sinai Hospital		2401	W. Belve	dere Ave	nue Balt	timore,	MD	21215		
Baltimore,	permit. Page 1 and Department of Heal Important: If item 3 any injury or other		20c. Location	c. Location - City or Town, State									
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Baltimore, MD 21201												1	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.											
	h, sician/												
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			30. Name and address of person who		(Item 23a) (Tuna		3-00		30,00	3010	1-211	•	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 3389 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Victor H. St. Martin \mathbf{P}^{M} October 2011 12:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Gildhrist Center Baltimore Towson Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Aug. 23, 1928 213-26-6274 Maryland Director 1**√** M 2 □ F 83 Yrs. Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2809 Jomat Avenue 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Completed 3 ₩ Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Bethlehem Steel Roll Turner 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Victor N. St. Martin Blanche K. Kemper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 Victor St.Martin-son 15 Parkview Drive-Seven Valleys, PA 17360 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Moreland Memorial
Park 1 Burial 2 Cremation 3 Removal from State Oct. 26, 2011 Parkville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Evans Funeral Signature of Funeral Service Licenses Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Kemi disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has filled in by the funeral director, page 2 autopsy perform 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence Other (Specify) Hospice 1 🗆 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending work? 2 🗌 No Investigation within 24 hours after deat To the Funeral Director. 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certif Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) ature and the 29b. 29d. Date signed (Month, Day, Year) 00071287

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Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Month, Day,

Date filed

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32. Registrar's

MOFFETT, SHIRLEY
Box 68760 Baltimore. Maryland 21215

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DIVISION	al or A s after al Director		4 ☐ Homicide determine							n (Street and Number or Hural Houte Number, Town, State)							
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	o the		only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)														
	F S F O		Auto		RES 000					OCTOBER							
	Lev	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)															
			Airlen Pan, MD 31. Date filed (Month, Day, Year)	Sinai Hospi 32. Registre		of Ba	ITMO	Re									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33893 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year 0:40P 01 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death zale ove VSINE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | Min. | June | 30,1917 Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 1 🗆 M 2 🗶 F **Director** 525-05-3753 94 Yrs Usual Residence of Decedent items 23a or 28a-f show ner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a or 28a and injury or other traumation was a second of the second of th 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9922 Linden Hill 21117 Road USA . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give þ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Mortician Funeral Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Carlton Mullins Helga Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9922 Linden Hill Road, Owings Mills, MD Mark Badin Grandson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 🕅 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Cremations 10/24/2011 Hampstead, MD of Fune Signatur Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road iwayne Osterlin Eline Funeral Home Reisterstown, MD 21136 23a. Part 1 Enter the disease, or complications that cause shock, or near fature. List only one cause on each lin disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Me Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit 0 that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical m Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
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To the Funeral D

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WW 3326 2122 enson

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State

Registrar

31. Date filed Month, Day, Year)

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2011

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state Amend Item 25 per me,g920,10/21/2011dhb Certificate of Death 3896 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Elayne Physician/ Metter Angust 21:25 PM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore opki If Under 1 Year If Under Security Numbe Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 K F Days Months Hours Min. Country 1171071950 549-72-2144 60 CA **Director** Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f sho 10c, City, Town or Location death with the Maryland Director 1 Yes 2 No MD HOWARD ELLICOTT CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4626 LIVE OAK COURT 21043 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 🖾No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced WHITE the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Page 1 and 2 should be MURRAY WINAGURA ADELINE PHILLIPS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau EARL JEFFREY METTER/HUSBAND 4626 LIVE OAK COURT, ELLICOTT CITY, MD 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 K Removal from State Ponation 5 Other (Specify) MINNEAPOLIS JEWISH CEM 08/10/2011 RICHFIELD, MINNESOTA of Funeral Sery 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Part 1. Enter the disease, or complicate shock, or heart failure. List only one complete the complete shock of ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Intracrania hemorrh disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): CERTIFICAT Physician/Medical P.O. Box 68760 attending IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 💆 No Day Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tyes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law mithin 24 hours after death.

To the Funeral Director; After this certificate has be cate has I page 2 s autopsy performed? Yes 2 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) MD 2011 RESOOO August 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Cheno MD 31. Date filed (Month De 600 North Walfe Street, Baltimore 3. Registrar's Signat State Registrar

Justin Keith Martin 11-07755 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 33895 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 16, 2011 0303 hrs Medical Examiner Justin K. Martin 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Harbor Hospital None 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) **Funeral** oreign Months Days Director August 8,1988 country Maryland 214-27-1945 1X M 2 F 23 Yrs Usual Residence of Decedent ij 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show 1 Yes 2 No Millersville Maryland Anne Arundel hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ճ 8250 Elvaton Road 21108 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes f Yes, Give Year White 3 Widowed 4 Divorced Yes 2 X No specify: Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after
Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natural",
injury or other tranmatic event, the Medical Examiner. Specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry leted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Comple Automotive Mechanic 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Keith Thomas Martin Terry Lynn Funkhouser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Metispa Drive, Severna Park, Maryland 21146 Terry Lynn Martin/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) West Arundel Crematory 1 Burial 2 X Cremation 3 Removal from State October 4 Donation 5 Other Specify: 2011 Odenton, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Will Exporer M00672 23a. Part I. Enter the disease, or compliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medica Death a Methadone Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last e attending physician and for use as the burial - trans Physician/Medical X UNPENDED AMENDED 23a, 27, 28a-f, per me, g921 11-7-11 smThe law requires that the death certificate be Box 68760, 23d. Date of delivery JE FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has l performed? ✓ Yes 2 No death? 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Other Nursing Home 5 Residence 6 Other this ၉ No 1 🗸 Yes 28a. Date of Injury (Month, Day,Year After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 1 Yes 2 X No unknown 24 hours after death. To the Funeral Director: fd 10-16-11 fd 2:35 am 2 ___ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2728 Bokkert Dr. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be determined found:private dwelling 4 Homicide Baltimore, Md. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 💓 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 16, 2011

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signal

30. Name and address of person who completed cause of death (Item 23a)

2. Registar's Signature

ORIGINAL

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ William Michael, Jr. 2011 2:20 P October 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 204 Wellham Avenue NW Glen Burnie Anne Arundel Co. Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Min. (Month, Day, Year) 212-28-3965 **Director** 1 **X** M 2 □ F 80 1931 Maryland April 1, Usual Residence of Decedent 3a or 28a-f shov t be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🌠 No Anne Arundel Glen Burnie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a (must be Funeral 204 Wellham Avenue NW 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ₭ Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates marked other than "natu matic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore Gas & Elementary/Secondary (0-12) College (1-4 or 5+) Lineman Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental F မ of Health and Menta fitem 27 is marked rother traumatic e Michael, Sr. Margaret Gorman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Michael / Wife 204 Wellham Avenue NW Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State o <u>=</u> 0 1X Burial 2 Cremation 3 Removal from State Department of Important If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk. 10/26/2011 Elkridge, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave. SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or comminations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ JANGRENE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** 2543210 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed after death. Cause (Disease or injury that initiated events resulting in death) Last theros signed by the attending physician and defached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown plnous 24b. Were autopsy findings available prior to completion of cause of death? SION 24a. Was an cate has by page 2 s autopsy performed? after death.

Director: After this certificate! 1 Yes 2 No 1 Yes 2 No funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 1 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 🔀 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 24 hours a Medical 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 10,21,2011 054574

Registrar

DHMH 17 Rev 06-2011

State

N. CRAIN

32. Registrar's Signature

HWY

64 GLENBURNIE MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

2 5 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <u>October</u> 18, 2011 Physician/ 7:50P MARIE KEVIN MUELLER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore Maria Health Care Center 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) Funeral 1 M 2 XX Months Days Hours 03/2494922 Marviand 89 Director 214-56**-**8030 Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location aţ Director ral", or items 23a or 28a-f s Examiner must be notified 1 ☐ Yes XX No <u>Maryland</u> Baltimore Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a 21212 USA 6401 North Charles Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 XX Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes XX No Specify. Specify: White "natural". Completed 3 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mary Frances Mackey H. Gerard Mueller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 6401 North Charles Street Baltimore, Maryland 21212 Sister Bernice Feilinger SSND 20c. Location - City or Town, State 20b. Place of Disposition (Name of XX Burial 2 Cremation 3 Removal from State Villa Maria Cemetery 10/25/11 Glen Arm, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FaMitchell-Wiedefeld Funeral Home Inc gnature of Funerals 6500 York Road Baltimore, Maryland 21212 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Part 1 Enter the disease r complication shock, or heart failure. List only Immediate Cause (Final Physician day disease or condition Medical resulting in death) ue to (or as a consequence of). Examiner lo month Sequentiary list nor ellions if any, leading to immediate cause. Enter Underlying Exami -transit Cause (Disease or iinjury that initiated events Dran and Due to (or as a consequence resulting in death) Last physician a Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 the use as 1 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ for 1 in the past 12 months? Month Year Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy performed? Yes 2 No Antemia 2 No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 💢 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident injury work?
1 ☐ Yes 2 ☐ No 5 Pending Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined 24 hours a Funeral L Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State Registrar

filed (Month, Day, Year)

ature and title of certifie

only one) 29b. Sign

and address of person who completed cause of death (Item 23a) Type, Print

within 2

To the F

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1.0-20-201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month 5:40 AM Physician/ 2011 10 20 Campbell Mitchell, Sr. Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Silver Spring Riderwood Village 8. Date of Birth (Month, Day, 08 23 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) **Funeral** Min. Days Hours DC 1 X M 2 □ F 88 578-09-8191 Director Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10b. County 10a. State filed within 72 hours after death with the Maryland Director 1 XYes 2 ☐ No Silver Spring Montgomery MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral IISA 20902 1408 Caddington Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. and Mental Hygiene.
is marked other than "natural", or iter
aumatic event, the Medical Examiner. Armed Forces? 1 X Yes 2 No 1950-Black, White, etc. Completed by 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 K No Specify. 1953 3 🔀 Widowed 4 🗆 Divorced Year or Dates. 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Patent Examiner 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ Lillian H. Ford 1 and 2 should be fif Health and Mental Item 27 is marked Alonzo R. Mitchell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1408 Caddington Ave. Silver Spring, MD 20902 Kimberly J. Mitchell/Daughter permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 01/18/2012 | Arlington, VA Arlington Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service licensee once. 4217 9th St. NW Washington, DC 20011 derson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Cardiac Arrhythmia Medical resulting in death) Due to (or as a consequence of) Examiner Atherosclerotic Cardiovascular Disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of, as the burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day Year in the past 12 months? Pregnant at time of death Yes 2 No g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown Atrial Flutter 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 XNo 1 Yes

the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 P.0. Records. Division of Vital

Maryland 21215-0036

Baltimore,

Completed by page 2 performed Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 I ER/Outpatient 3 I DOA မ funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 X Natural 5 Pending Accident Suicia s after death. M Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier npleted f (Check Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on To the within 2
To the comple 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatu 10/20/2011 D24035 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Rd. Silver Spring, MD 20904 E.S. Machado 32. Registrar's gignature 31. Date filed (Month, Day, Year) State OCT 2 5 2011 Registrar ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

		For State of Maryland / Department of Health and Mental Hygiene 1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No 2 0 1 1									00000			
			Registrar 1. Decedent's Name (First, Middle, La	ast)	lineate of D	eaui	g. No.	1	3 3 8 9 9 3. Time of Death					
	Physicia Medi		James	Niroda, SR.				13 Z	Year I	6'.25P M				
•	Examir	ner	4a. Facility Name (if not institution, given Seasons Hospice at		1	4b. City, Town, or Randa1			4c. County of Death Baltimore					
4	Funeral		Social Security Number 6.	Sex 7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birtho	lace (State or Foreign			
	Director	ı	216-24-0486 Usual Residence of Decedent	1 X M 2 □ F 81	Yrs.	Months Days	Hours Min.	Nov. 1, 1	29	Mary	and			
	and show dat	Ď	10a. State 10b. County		ty, Town or Loc					11	Od. Inside City Limits			
	Maryl 28a-f otifiec	irec		V/A		Baltim	ore				1 X Yes 2 □ No			
	h with the ns 23a or nust be n	Funeral Director	10e. Street and Number	rshall Street		10f. Zip Code	21230)	ng. Citizen of W	/hat Coun	try?			
9800	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Kores	lf	Vas Decedent of His Yes, specify Cuban Yes 2 X No	, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- America k, White, e				
15-(72 hou n "nat fedica	nplei	15. Decedent's (Specify only highest g	Education rade completed)	(Give k	ent's Usual Occupation of work done du		ing	16b. Kind of Bu	siness/Inc	ustry			
212	within giene. er thar		Elementary/Secondary (0-12)	College (1-4 or 5+)		NOT use retired) Ezenaker			Locke In:	sulato	r			
Maryland 21215-0036	should be filed within and Mental Hygiene. is marked other tha raumatic event, the N	To Be	17. Father's Name (First, Middle, Last)	James Niroda				e (First, Middle, Microblewski	aiden Surname)					
Mar	2 shou th and 27 is m traum		19a. Informant's Name/Relationship (James S. Niroda, Jr			g Address (Street ar				ate, Zip C	ode)			
	e 1 and 2 s t of Health If item 27 or other tra		20a. Method of Disposition	20b. F		Marshall St sition (Name of	1		nd 212.		vn State			
mo	Page 1 nent of ant: If it ary or o		1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	emetery, crem	enatory or other place, rematory. In)	1	Baltimore	•				
Baltimore,	permit, Page Department of Important: If any injury or once,		21. Signature of Funeral Service Licen		22.	Name and Address	of Facility Mc	ully-Polyn	iak Funer	ral Ho	me, P.A.			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
,	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardio Thrombonic event Due to (or as a consequence of): Athervs Clerotic Cardiovas Lular disease Sequentially list on the condition of the condi											
Medical resulting in death) a. Due to (or as a consequence of the con						consequence of):								
		ner	if any, leading to immediate	Due to (or as a consequ		arovase wie	XI GILEU			-				
	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C										
_	icate be executed physician and is the burial-transi	cal E	resulting in death) Last	Due to (or as a consequ	uence of):									
3760	ficate I g phys as the	Nedical		d										
. Box 68	is that the death certificate be executed gned by the attending physician and be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of c	ıl death 3 🔲	Ectopic pregnancy Other (specify)			23d. Date Mon	of delive	y Day Year			
P.O.	that the		Part II. Other significant conditions of	contributing to death but not res	ulting in the un	derlying cause give	n in Part I.	23e. Did toba	cco use contrib	oute to the	cause of death?			
rds,	requires been sig should b	ted						1 🗆 Yes	2 □ No 3	3 🗌 Prob	ably 4 Unknown			
Division of Vital Records,	ysician: The law re is certificate has bu director, page 2 sh	Completed by						24a. Was an autopsy perform	ed? pr		sy findings available apletion of cause of			
ital	certific rector,	Be	25. Was case referred to hedical examiner? 1 Yes 2 No	Hospital:		26. Plac	e of Death (Check	only one)						
of V	y Phys er this eral di	e: 10	1 ☐ Yes 2 M No 27. Mann of Death	1 Inpatient 2 28a. Date of injury	28b. Time of	3 DOA Other.	1	me 5 🗌 Residen 28d. Describe how			iens hospice			
on (ending sath. or: Afte he fun	ficat	1 Natural 5 Pending 2 Accident Investigation		injury	work?	es 2 🗆 No	edd. Describe now	injury occurred					
Divisi	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	l Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify,	me, farm, stree	et, factory, office		28f. Location (Stre City or Town,		or Rural F	Route Number,			
	he Hospi in 24 hou he Funer ipletely fill	Medical	(Check 2 \(\sum \) Medical Exam	sician: To the best of my knowliner: On the basis of examination se Practitioner: To the best of m	and/or investig	attion, in my opinion.	death occurred at	the time, date and	place and due t	o the caus	e(s) and manner stated			
	5 V V V V V V V V V V V V V V V V V V V		29b. Signature and title of certifier WSTCHIPW			29c. License n	7465		d. Date signed	+/11				
Ì	01/1		30. Name and address of person who	completed cause of death (Item	23a) (Type, Pri	n' N S	203	Bultim	ore M	021	209.			
i	Stat Registra	_	31. Date filed (Month, Day, Year) OCT 2 5 2011	32. Registrar's Signat	ure									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 22, 2011 Joseph George Otterbein 12:15 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A 3304 Hillen Road Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) March 19, 1923 Hours 220-14-6163 88 **Director** 1 【**X**M 2 ☐ F Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 3304 Hillen Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces' Black, White, etc. þ 1 Never Married 2 Married **□X**Yes 2 No WII 1 Yes 2 No Specify. If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced White item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene **Owner** Bakery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) August Otterbein Augusta Hilbinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trai Karen Hunter / Daughter 3304 Hillen Road Baltimore Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ŏ cemetery, crematory or other place, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 10/26/11 Brooklyn Maryland 22. Name and Address of Facility Inc. 305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (ar as a consequence of, if any, leaching to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): s been signed by the attending physician is should be detached for use or the borner. Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Dav Year Pregnant at time of death 9 Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? σ. or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an in by the funeral director, page 2 performa 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 **X**No Other: ျှ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at Natural Accident 5 \square Pending work? 2 🗌 No Investigation hin 24 hours after deat the Funeral Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner To the course of the cause (s) and manner stated Certifying Nurse Practitioner To the course of the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated Certifying Nurse Practitioner To the cause (s) and manner stated (s) and manner stated (s) and 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TACLIC JONE Date filed (Month, Day, Year) JONES CLNP Registrar's Signature State Registrar DHMH 17 Rev 06-2011

12:15am

3

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fth 9921 11-4-11 yt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month James O. Pittman 2ctobes Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL Baltimore 5. Social Security Number 246 If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthdav) Funeral Hours **Director** 1 😿 M 2 🗆 F 69 Yrs. Usual Residence of Decedent 5/18/1942 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director P. TTMON PA Littlestown 10e, Street and Number 9 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 17340 233 S. ColumbusAve. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 X Married ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event the conce. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Security Company <u>Security Officer</u> vrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eva Pittman Emanuel Hannah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 233 S. Columbus Ave. Littlestown, PA 17340 Betty S. Pittman-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) House Family Cemt. 10/28/2011Tillery, N.C. Donation 5 Other (Specify) 22. Name and Address of Facility March F/H 1101 E. North Ave. Baltimore, MD 21202 21. Signature of Funeral Service Licensee Mylin 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph. sician/ disease or condition resulting in death) prebrovaso Medical to (or as a consequence of **Examiner** pertensia. Sequentially list conditions, Examiner or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as IF FEMALE be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 1 Yes 2 No a Unknown Division of Vital Records, P.O. ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? ģ 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b, Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy accidents perform 1 Yes 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: ျ 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this 27. Manner of Death 1 Matural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work' Accident 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Marcus Sinai Hospital

02110 AM

9. Birthplace (State or Foreign

10d Inside City Limits

Approximate Interval Between Onset and Death

Day

2 1 No

1 Yes

Year

Month

1 Yes 2 No

N.C.

2011

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ -ORRAINE Peterson 11:01 AM OCTOBER 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST RANDALISTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Director 79 213-30-3522 07 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD NA Baltimore 1 XYes 2 No 10e. Street and Number ò 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 7228 Croydon Road 21207 U.S.A. or items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Black Completed 3 Widowed 4X Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) it of Health and Mental Hygiene.
If item 27 is marked other than
or other traumatic event, the Ms Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade na Logistics Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Malcolm Smith Ollie Mae Douglas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maurice Peterson-Son 1138 Kinsburg Road, Owings Mills, Md 21117 20a. Method of Disposition 20b. Place of Disposition (Name of Department of h Important: If ite any injury or ot once. 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Memorial Park 10/28/20**1**1 Woodlawn, Md 21. Signatur of Funeral Service Licens 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ SMALL CELL LUNG disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events y physician ar is the burial-t resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) ____ Day Pregnant at time of death Month Year 9 Unknown P.O. Hospital or Attending Physician: The law requires that the by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, NEUTROPENIA 1 Yes 2 No 3 Probably 4 Unknown ISCHEMIC CARDIOMYOPATHY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an this certificate has autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Tes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completed filled in by the fu Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the hasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated her. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying N only one) 29b. Signature and the 29d. Date signed (Month, Day, Year, D0060293 OCTOBER 2011 MD

Registrar
DHMH 17 Rev 7/2009

30. Name and address of p

OLD COURT RD

MD 21133

death (Item 23a) (Type, Print)

5401 0

I.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Year Florence Emma Platek OOM Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death elter Health and Behabilitation Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🛛 F 03/28/1924 (Month Day Year) 217-12-3258 Country) Director Yrs 87 Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Tes 2 X No Harford Bel Air 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 122 Bright Oaks Drive 21015 U.S.A. items hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: 3 X Widowed 4 Divorced Specify. Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Operator Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Aubrev Bullock Caroline Nuener I and 2 should be Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra Mary Sue Kowalewski, Daughter 122 Bright Oaks Drive, Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Svc. Corporation | 10/24/2011 Towson Maryland 22. Name and Address of Facility Signature of Funeral Service Licensee Leonard J. Ruck, Inc. Controvalle 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) onsequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery the past 12 months?
Yes 2 \sum No be detached for Day Year Pregnant at time of death 1 Yes 2 Unknown the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? After this certificate 1 ☐ Yes 2 ☐ No Yes Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 ANO Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Division of 27. Manner of Death the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be To the Hospital or Attend within 24 hours after deat To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D56545 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHIUI KNOSHA 615 U-MACHAL R.) #106, BELAIR

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Antoinne Pratt 11-07787 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk Unk State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Physician/ nt's Name (First, Middle,Last) 2. Date of Death Month Day October 17, 2011 0333 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Johns Hopkins Hospital Baltimore 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 9. Birthplace (State or **Funeral** Months Davs Hours Min Director Country) 1 M 2 F Usual Residence of Decedent 'n 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No or 28a-f show hours after death with the Maryland Director Street and Number 10g. Citizen of What Country? 10e. , or items 23a or 28a-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 No Yes 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year event, the Medical Examiner other than "natural". ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 1 Department of Health and Mental Hygene. Important: If item 27 is marked other than ", injury or other traumatic event, the Medical E **Baltimore, MD 21215-0036** Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State, Zip Code) 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place 1 W Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify Signature of Funeral Service Licer 22. Name and Address of F Part I. Epifer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or failure. Est only one cause on each line. Home, P.A. Physician Between Onset and /Medical a. Multiple Gunshot Wounds Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and certificate be executed Physician/Medical UNPENDED attending physician or use as the burial -AMENDED Box 68760, IF FEMALE: 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ě 1 Yes 2 No 3 Probably 4 Unknown Completed s certificate has been rector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital or Attending Physician: Hospital: 1 ☐ Inpatient 2 ✔ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other After this 1 Yes 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 27. Manner of Death Certification: Oct 17, 2011 Subject was shot Natural 0129 hrs 5 Pending 1 Yes 2 V No within 24 hours after death.

To the Funeral Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 1700 Harford Avenue, Baltimore, MD (Specify) In a car in local street 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Ling Li, MD

and manner stated

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

October 17, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G921, 11717/2011, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month am Viirainia 5 - 2 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Overlea Nursing Home Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) 1 M 2 J 99 Months Days Hours Min 220-01-1028 Director 191 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at death with the Maryland 10a, State 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2412 E. Lafayette Ave. 21213 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. þ 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 - Widowed 4 - Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene. Johns Hopkins Elementary/Seconday (0-12) College (1-4 or 5+) Laundry Hospital 6+h Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Henry Tankard Delia Knox other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Gladys Parham (niece) Cedar Heights Ct.Balto, Md. 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State P Burial 2 Cremation 3 Removal from State Nov. 4, 201 4 ☐-Donation 5 ☐ Other (Specify) Mem.Pk. ing Balto, Md 21, Signature of Funeral Service License Calvin B. Scruggs Funeral Home Preston St. Balto, Md. E 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Examine Duit to (or as a consequence ut, Cause (Disease or iinjury that initiated events resulting in death) Last r Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of): attending physiciar Physician/Medical P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ò Day Pregnant at time of death detached the g Unknown þ been signed the should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown has been 24b. Were autopsy findings available 24a. Was an page 2 autopsy performed Yes 2 No prior to completion of cause of death?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (ftem 23a) (Typs, Print) 560 toen Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33906 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month KIN 0550AM 201 0 /Medical Town, or Location of Death give street and number 4c. County of Death Examiner Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X Director ce of Decedent 10a. State 10b. County 10c. City, Town or Location Inside City Limits 28a-f show at Items 23a or 28a-f sh ner must be notified 1 res 2 No Director timore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a DINING Funeral Was Decede It Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ Yo Specify þ 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed withir Hygiene. College (1-4or 5+) marked other unould be file.
Alth and Mental Hve. 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19a. Informant's Name/Relationship Type. Print) Department of Health ar Important: If item 27 is any injury or other trauonce. V. Las Vegas Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition **W**Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signatur, of Funeral Servi e Livensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. ying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ue to for as a nonsecuence of The law requires that the death certificate be executed and burial-t Due to (or as a consequence of) P.O. Box 68760. physician s the buria Physician/Medical attending 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 Yes 2 No 3 Probably 4 Wonknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy perform 1∐ Yes 2 No Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home After this 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ∏No 24 hours after death. 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier (Check only one) 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 201 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 22. 2011 8:45 A M Raymond Nickolas Potts Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 208 Colgate Drive Forest Hill 8. Date of Birth (Month, Day, NOV • 13 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) Maryland 1 XM 2 DF Days Hours 76 Director 219-30-6457 1934 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XNo Forest Hill Maryland Harford ä 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21050 USA 208 Colgate Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 Divorced 4 Divorced Specify: White Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Manager Petroleum Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margaret (unk) Kraft Edward (unk) Potts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Colgate Drive, Forest Hill, Maryland 21050 Theresa Potts / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Spent tombment Bel Air, Maryland Bel Air Memorial Gdn. 10/26/2011 of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that dauged the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 12 disease or condition resulting in death) Leiner Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): and I-transit Cause (Disease or iinium that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical The law requires that the death certificate be 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cormanding performed? Yes 2 No 1 Yes 2 No within 24 hours after death. To the Funeral Director: After this certifica completed filled in by the funeral director, it Hospital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 2 No 1 🗌 Yes ရ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier

State Registrar 30. Name and address of person

OCT 2 5 201

10 1

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ESTHER PELZER Medical toper 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Sinai Hospital of Baltimore Boltimore N/A 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 070**-**16-1885 94 **Director** 1 □ м 2**ХХ**Б 04/27/1917 NY Usual Residence of Dec 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 4006 BROOKHILL ROAD 21215 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: WHITE Completed 3 X Widowed 4 Divorced Specify: and Mental Hygiene. is marked other than "natural aumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) attent Known as TEACHER **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 27 is marked r traumatic e JOSEPH 1 **TOPOR** RACHFL UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDY PELZER/DAUGHTER permit, Page 1 and 2 Department of Health Important: If item 2: any injury or other t once. 4370 PARKTON STREET, BALTIMORE, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ARETINGTON CEMETERY CHIZUK AMUNO 4 Donation 5 Other (Specify) 10/23/2011 BALTIMORE, MD 21. Signature of Funeral Service Hoensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Palmonary Physician/ plications disease or condition Medical resulting in death) 25 days Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events and burial-tran resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 Yes 2 No 9 Unknown igned by the a be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Piabotes MelliTus Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv performed? Altery e Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate it COVONOVY 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 29b. Signature and title of certifie RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 V

State Registrar 32. Registre s Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 3:00 October 0 Albert Thomas Rayner Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 1618 Schucks Road Harford Bel Air 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) 215-12-7764 Director 1**X** M 2 □ F 88 Yrs. June 8, 1923 Maryland Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location aţ 10a. State Director item 27 is marked other than "natural", or items 23a or 28a-f so other traumatic event, the Medical Examiner must be notified 1 Yes 2 No Bel Air Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21015 1618 Schucks Road USA 14. Race - American Indian, 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? Black, White, etc. ρ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Residential Building Builder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bertha Berkhardt John T. Rayner Department of Health and Important: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1600 Schucks Road Bel Air, Maryland 21015 Diane T. Moorefield, Daughter 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 D Burial 2 X Cremation 3 D Removal from State Metro Crematory Inc. 10/24/11 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between et and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** PERTENSID Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death 2 No 1 Yes 2 La 9 Unknown g Unknown P.O. by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕊 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy abed within 24 hours after death.

To the Funeral Director: After this certificate 2 🗌 No Yes 2 No 1 🗌 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) or Attending Physician: Be examiner? Hospital Other: 1 Tyes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 🗌 Yes 2 🗆 No 1 Natural 2 Accident 5 Pending Investigation the Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by determined building, etc. (Specify) To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of 29d. Date signed (Month. Dav. Year) M se of death (Item 23a) (Type, Print) Name and address of person who completed ca

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

ADV

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year Physician/ Sr Kobert Randall 8:47 PM 2011 october Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4918 Cordelia Ave Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months (Month, Day, Hours 216-36-3571 **Director** 1**X** M 2 □ F MD 09 40 71 01 28a-f show 10d. Inside City Limits aţ 10a. State 10b. County 10c. City, Town or Location Director Examiner must be notified 1 X Yes 2 No Baltimore NA MD or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. 21215 4918 Cordelia Ave "natural", or items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) l Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Wilbern Company Maintenance 8th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ည Ruth Jennings Wesley Randall permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4918 Cordelia Ave, Baltimore, Md 21215 Beverly Randall-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Donation 5 Other (Specify) 10/22/2011 Pikesville, Md Druid Ridge 22. Name and Address of Facili 21. Signature of Funeral Service Licenses March F/H West Baltimore, Md 21215 4300 Wabash Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician (uncer Lung disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or Injury tran and that initiated events resulting in death) Last Due to (or as a consequence of): as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death 1 Yes 2 L 9 Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Funeral Director: After etely filled in by the funer Natural iniury 5 Pending Accident death Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by determined after City or Town, State) 24 hours Medical 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, detail occarried at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

MS Raj apane M.D

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· Rajapakse, M·D

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

32. Registrar's Signature

SMITH AV

D0057465

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Baltimore

10/20/11

MD

21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month October 7:49 Louis H. Robinson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3000 Seabury Road, Unite F Baltimore n/a Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Hours Min Director 212-36-8520 Usual Residence of Decedent 28a-f show 10a. State items 23a or 28a-f shoner must be notified at 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 √Yes 2 □ No MD Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3000 Seabury Road, Unit F USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner Black, White, etc. 50 1 Never Married 2 X Married 1 Yes If Yes, Give 2 **X**No Baltimore, Maryland 21215-0036 Specify: African-American 1 ☐ Yes 2 XNo Specify: "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Kopflex & Company **Machinist** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Henderson Robinson Elizabeth Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is, any injury or and 3000 Seabury Road, Unit F. Baltimore. MD 21225 Helen Robinson/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 10-29-2011 Dulanev Vallev Timonium, MD of Runeral Service Ligens Signatu 22. Name and Address of Facility While Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 Approximate Interval Between Onset and Death se the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that of shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): physician and s the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months? Month Day Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contrib death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tyes 2 No 3 Probably 4 LUnknown 24b. Were autopsy findings available 24a. Was an this certificate has autopsy performed Yes 2 prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate ha completed filled in by the funeral director, page 2 No 1 TYes Be (25. Was case referred to 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certificate: 27. Manus of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? Accident 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) To the Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) ddress of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER Physician/ MA PO:00 SAMES 201 RANO Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MEDICAL CENTER BALTIMORE WASHINGTON ARUNDEL DURNIE GLEN HNNE If Under 1 Social Security Number 7. Age (In yrs. last birthday) 72 Yrs. Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New Jersey 139-30-9740 1 🛣 M 2 🗆 F Months Hours Min. 06/25/1939 **Director** Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State death with the Maryland Completed by Funeral Director Glen Burnie Anne Arundel 1 XYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21061 516 N. Crain Highway USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status rmed Forces?

X Yes 2 □ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Vietnam Year or Dates Vietnam 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) RYNO, JAMES <u>Salesman</u> <u>Private</u> 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Elsie Elizabeth Pine Albert Ryno Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
18 Virginia Avenue NW, Glen Burnie MD 21061 19a. Informant's Name/Relationship (Type, Print) Theresa Teixeira (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Ardent Cremation 1 Burial 2 X Cremation 3 Removal from State 10/26/2011 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Latimore Funeral Services, PA 2818 E. Baltimore Street, Baltimore MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 20445 **EUMOHID** disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No page 2 should be detached for Day Year 5 Other (specify) Month Pregnant at time of death the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be 10 Other: 2 🗶 No 1 Yes 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending 24 hours after death. Funeral Director: A Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) De Com Brus De Cion & soco P1553000 OCTOBER 24,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GUILLE AHO GIANGRECO 301 HOSPITAL DRIVE, GLEN BURNIE, HD 20161

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

OCT 2 5 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Thomas Joseph Riess October 20, B:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Manor Care Rossville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Jan 28, 1937 Maryland 213-34-3092 74 **Director** Usual Residence of Decedent per nt. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director Maryland Baltimore 1 X Yes 2 No 10g, Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code Funeral 3905 Inner Circle 21225 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2X Married ģ Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: If Yes, Give 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pipe Fitter Ship Yard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Riess Estella Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Garcia step daughter 1 Tamarac Trail Baltimore, Maryland 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Memorial Park Oct 24, 2011 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Cully Polyniak Funeral Home P.A. 21. Signature of Funeral Service Live 237 E. Patapsco Avenue Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final WILL Physician/ percar disease or condition resulting in death) Medical Due to (or as a cons unice of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Yes 2 No been signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? 2 - No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to riedical 26. Place of Death (Check only one) Be examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne f Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗆 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D69540 25 1105 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year OCT 2 5 2011

01700

Mam

32. Registrar's Signature

State Registrar

Box 68760

Records, P.O.

Division of Vital

Columbia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) OCT 2 5 2011

NorthRd.

32. Registrar's Sanature for Management

R109061

Nettina, Nurse Practitioner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ William Walter Schmidt October 18 2011 12:54 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Charlotte Hall Veterans Home St. Mary Charlotte Hall 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖫 M 2 🗆 F Months Hours (Month, Dav. Year) Country Director 22-4314 March 25, 19 28 Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits 10c. City, Town or Location notified at Director 1 Yes 2 No Anne Arundel Pasadena MD 10e. Street and Numbe 10f. Zin Code 10g. Citizen of What Country? ò er than "natural", or items 23a or the Medical Examiner must be Funeral 7832 E. Shore RD permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 Specify. White 1 ☐ Yes 2 🙀 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or DateWII Korea 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Horse Race Track Maintenance Horse Racing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ John Schmidt Edith Hudnut 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shore Rd. Pasadena MD 21122 7832 E. Margaret Ginevan Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Oct 20 2011 Brooklyn Park MD Cedar Hill Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McCully Polyniak Funeral Home PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph, sician/ ARDIAC ARRTHYMIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner NEMIA Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine MYELO DYSPLASTIC SYNDROME ending physician and use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending narwaining. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Year Pregnant at time of death i signed by the ail Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISEASE PARKINSONS 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? page 2 1 ☐ Yes 2 ₺ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: ျှ 1 Yes 2 LAK 1 Inpatient 2 ER/Outpatient 3 DOA 4 Unursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending iniury 1 Natural ∴ atural

☐ Accident
☐ Suice Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar LEENA

31. Date filed (Month, Day, Year)

OCT 2 5 201

D0067788

10.18.11

MD

32. Registrar & Signature

KODALI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9610g Per FH G920 10/26/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar 33916 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 19, 2011 Hedwig 11:00p M Sears Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 430 Battery Drive Havre de Grace Birthplace (State or Foreign If Under 1 Year If Under Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours (Month, Day, Year) 09/24/1926 1 🗆 M 2 😿 F Days 85 Director 213-71-1628 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d, Inside City Limits aţ 10c. City, Town or Location Director iral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 No Harford Maryland Havre de Grace 10e. Street and Number 10f. Zip Code 10g. CitiAen of What Country? Funeral 20178 Austria 430 Battery Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: ed other than "natural", event, the Medical Exar Specify: White 3 Widowed 4XXDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) secretary government 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Josep Pauli Kamilla Steiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ingrid Barton (daughter) 430 Battery Drive, Havre de Grace, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State R.A. Ferris & Company 10/21/2011 4 ☐ Donation 5 ☐ Other (Specify) West Chester, PA 21. Signature of Funeral Service Licenses Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Ons, t and Death shock, or heart failure. List only one cause on Immediate Cause (Final herman Physician/ anknown disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Dav Month detached signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2002332-2 Jackdew 5 mb 10.21.2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. S SACHDEV MD 126 A, E High ST Elekan MD21921 126 A, E High 31. Date filed (Month, Day, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SIMPKINS 0425 OCTOBER 2011 Medical 4c. County of Death Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CENTER FOR HOSP TOWSON Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Min (Month, Day, Year) Country) Director 1 □ M 2 X F 62 NORTH 06/28/ 28a-f shov 10d. Inside City Limits 10a. State aţ 10c. City, Town or Location Director Examiner must be notified 1 XYes 2 □ No BALTIMORE MD ō 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a 21218 U.S.A. LOCH RAVEN 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify BLACK 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4 or 5+ and Mental Hygiene. HOME MAKER 4 OUSE WIFE 17. Father's Name (First, Middle, Last) မ DEORGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SimpKin . Page 1 and 2 sl tment of Health a tant: If item 27 is RAVEN BLUD, BALTIMORE, MARY/AND 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 31/2011 BALTIMORE, MARY LAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit DERRICK C. JONES FIH, PIA. re of Funeral Service Lice BALTIMORE, MD. 21215 23a. Part 1. Enter the disease, or complications that caused the death o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): and I-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician all for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 1 ☐ Yes 2 9 ☐ Unknown the signed by t Id be detach 23e. Did tobacco use contribute to the cause of death? à Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has To the Hospital or Attending Physician: The this certificate 1 🗌 Yes 2 🗌 No Yes Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 4 Nursing Home 5 Residence 28b. Time of Manner of Death 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 24 hours after death.

Funeral Director: After letely filled in by the funer 1 Natural 2 Accident (Month, Day, Year) 5 Pendina Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b. Signatu Atitle of cer 29d. Date signed (Month, Day, Year) D0071187 Name and address of person who completed cause of death (Item 23a) (Type, Print) "Suite 4105, Baltinulle 1MD 21201 Shaheey, 6701 N. Challs 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PCHIBER 921 11:27 M Brenda Kay Shorter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Ye March_26, 1 □ M 2 🛭 F Hours Min Virginia 62Yrs. Director 214-54-9971 1949Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1254 Birch Ave. 21227 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 Xo Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Food Service 12 N/A Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) of Health and Mental H of Health and Mental H if item 27 is marked ot r other traumatic ever မ Sidney A. Ellis Margie Marie Hodge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ige 1 and 2 sh nt of Health a t: If item 27 is Jeff Shorter / Son HC 78 Box 31A1, Rockcave, WV., 26234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If if
any injury or o 1 X Burial 2 Cremation 3 Removal from State Meadworidge Mem. Park Oct.21,2011 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. Signature of Funeral Service Licenses 1328 Sulphur, Spring RD., Arbutus, Maryland 21227 Tart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ABDIMINAL Immediate Cause (Final INTRA Onset an Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Day Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by RYPTOGENIC OF THE LIVER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown FALLUCE Were autopsy findings available prior to completion of cause of death? autopsy perform this certificate 1 🗌 Yes Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Division of 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier P24067 MEDICAL 1-65/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD MIE 21229 PAUL OSME JOHN

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

5

Breno/

RRITER

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 33919 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5m 19 X DSALIE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 306 Mansion Drive Apt.10 Cecil Perryville Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 218-70-3113 **Director** 1 □ M 2X□ F 55 Sept 26, 1956 Maryland Usual Residence of Decede ifiled within 72 hours are traited Hygiene.

ed other than "natural", or items 23a or 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Perryville Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21903 USA 306 Mansion Drive Apt.10 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sewing Industry n and Mental Hygien 7 is marked other th Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev မ Leila Boyce William C. Hurt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Mansion Drive Apt.10 Perryville, MD 21903 Brian Hurt, Brother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/24/11 Metro Crematory Inc. Baltimore, Maryland Signature of Funeral Service License Thomas Gregor Name and Address of Facility Of Maryland, Inc. 19 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Ances disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events physician and sthe burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Box 68760 as attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Day Month Year Pregnant at time of death the Unknown 9 Unknown P.O. signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bage 2 s autopsy perform 2 No 1 🗌 Yes Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 \sum Yes Other: 4 Nursing Home 5 Residence 2 PNo 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1
Yes Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer Natural 5 \square Pending 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Ercertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title

State Registrar 31. Date filed (Month, Day, Year)

OCT 25

Name and address of person who completed cause of death (Item 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 23^{Day} Oct. Physician/ 2011 11:47p^M Schommer Shirley Marie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Richey Hospice Baltimore 7 8. Date of Birth (Month, Day, June 8. 9. Birthplace (State or Foreign Country) Canada Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days 1 🗆 M 2 🗜 F Hours Min Director 547-48-8606 76 Yrs 1935 <u>June</u> Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 1 Yes 2 No 1 N/ABaltimore City Maryland 10e. Street and Number 10g, Citizen of What Country? ሌ 23a by Funeral 838 North Eutaw Street 21201 United States , or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc. 9 1 Never Married 2 Married 1 ☐ Yes 2 X No Maryland 21215-0036 1 Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced If Yes, Give "natural", Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Other People's Elementary/Seconday (0-12) College (1-4 or 5+) Homes House Keeper 6 injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o မှ Unknown Rosenburg Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Robbins, Jr./Executor 508 S. Charles St., Baltimore, Maryland 21201 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 10/25/2011 | Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) METASTATIC SMOS Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown has been signed by the e 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate har funeral director, page performed? 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Spe Hospital: 2 110 မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pendina Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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-	Funeral		5. Social Security Number 6. Se		If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)						
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21215-0036	d within 72 hours after death with the Maryland jiene. Ir than "natural", or itema 23a or 28a-f show The Medical Evantine must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☑ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☐ No Specify:	pecify Yes or No- o Rican, etc.)	Black, White, etc. Specify: Black						
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only 2 Madical Exam	ysician: To the best of my knowledge, death liner: On the basis of examination and/or in- and manner stated.	vestigation, in my opinion, death occu	erred at the time, date a	and place, and due to the cause(s)						
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. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 Pregnant at 9 Unknown	2 🗌 Fetal dea		Ectopic pregnanc Other (specify)	ey .			23d. Date of del Month	ivery Day Year
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	he Hosp in 24 ho he Fune ipleted fi	Medical	(Check 2 \bigsqcup Medical E	Physician: To the best of r xaminer: On the basis of ex Nurse Practioner: To the b	amination and/	or investi	gation, in my opinio	n, death occurred	at the time, date	and place,	, and due to the o	cause(s) and manner stated.
	Vor Vor	/	29b. Signature and title of certifier	L. Gori	na 1	4)	29c. License	565	71	29d. Dat	e signed (Mont)	, Day, Year) 2011
	31,8		30. Name and address of person v	who completed cause of de	ath (Item 23a)	(Type, Pr	HOWA	HRD CO	VINTY	GA	ENER A	AL.
K	Stat Registra	~	31. Date filled (Month, Day, Year)	32. Registrar	's Signature	مهميع						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 21 per fh,g920,10/25/2011dhb
Certificate of Death
Reg. No. 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCTOBER 10,2011 Physician/ Ε. Smallwood 10:11P M Annie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAINT JOSEPH MEDICAL BALTIMORE CENTER TOWSON Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours Min 1 🗆 M 2 🛣 218-46-0683 02/13/1945 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director ms 23a or 28a-f s must be notified MD **Baltimore** 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21239 1924 E. Belvedere Avenue ral", or items ? death Was Deceud... Armed Forces? Ves 2 **X** No 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, þ and 2 should be filed within 72 hours after theath and Mental Hygiene. tem 27 is marked other than "natural", or other traumatic event, the Medical Examir 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 X No Specify: Specify Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) F.W. Woolworth's Elementary/Seconday (0-12) College (1-4 or 5+) 12th Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Elmond Murphy Annie Dupree 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1924 E. Belvedere Avenue, Baltimore, MD 21239 James L. Smallwood Jr.- Husband other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Garrison Forest Cemetery 10/21/2011 Department of H Important: If ite any injury or ot once. ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral Services per DVR Winton Harris 4905 York Road, Baltimore, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC OVARIAN CANCER disease or condition Due to (or as a consequence of): SHOCK Medical resulting in death) **Examiner** Sequentially list conditions, if any leading to in mediat cause. Enter Underlying Cause (Disease or iinjury Due to for ea a nonsequence of: Examir SEPSIS ng physician and as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
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5 Other (specify) in the past 12 months? ģ Pregnant at time of death 2 No detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 I Inknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗙 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 s autopsy death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 No ည 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 26b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate; 24 hours after death. Funeral Director: After (Month, Day, Year) 1X Natural 5 Pending 2 🗆 No 1 Yes Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined Hospital 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D46356

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Mo

7601 OSLER DRIVE TOWSON, MD 21204

30. Name and address of person who completed duse of death (Item 23a) (Type, Print)

2. Registrar's Signature

KHOSROW TABASSI, M.D.

Please Type or Print in Black Indelible Ink / Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Mary Catherine Scally-Robertson 2 Date of Death Physician/ October 2011 22° Catherine Scally-Roberton 2:18 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Brightwood Center Lutherville Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 219-34-1226 73 Maryland **Director** Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and: If item 275 is marked of other than "natural", or items 23a or 28a-f show usy or other traumatic event, the Medical Examiner must be notified at. ury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 😾 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 702 Hampton Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Completed 3 Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Teacher</u> Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည В. Scally C. Lawrence Henrietta Deitrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tr once, Sarah J. DeSantis Daughter 702 Hampton Lane Towson, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation Other (Specify) Hilltop Service Corp. 10-25-2011 Towson Maryland 21. Signa ire 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death erebrovascular Immediate Cause (Final fred Joseph Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Seizne Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the g 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 No 1 Yes 2 No or Attending Physician; 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After 1 Natural 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 10-24-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DVING MOZNO NO 2/20 MIRBARA 05 lev 32. Registrer's Sign

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 6:00 PM Month Physician/ Schuppner Neville Edwina Medical 4a. Facility Name (if not institution, give street and number) 4c County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore SAINT JUSEPH MEDICAL CENTY Towson 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min (Month, Day, Year) Months Hours **Director** 218-14-0965 1 🗆 M 2 🗶 F Maryland 1/21/1926 85 Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director Timonium Baltimore 1 Yes 2 No Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral U.S.A. 514 Limerick Circle 21093 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White If Yes, Give Year or Dates th and Mental Hygiene. 27 is marked other than "natural", traumatic event, the Medical Exa 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Own Home Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Bechler Ida Maurice Neville I and 2 should be If Health and Me Item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Susan S. Maher / Daughter Towson, Maryland 21204 1613 Jeffers Road 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Page 1
Department of Important: If it any injury or of once. 1 X Burial 2 Cremation 3 Removal from State Timonium, Maryland 10/28/2011 Dulaney Valley Mem 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. uperal Service Licenses Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician RESPIRATOR disease or condition resulting in death) Medical TRUCTIVE PULMONA DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and I-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician all for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Month 5 Other (specify) Pregnant at time of death Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 X 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 24 hours after death. Funeral Director: After this 28c. Injury at work?
1 Yes the funeral 28a. Date of injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury Natural Accident 5 Pending 2 🗌 No Investigation 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, beautiful course at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29d. Date sign 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER TIMOTHY LOW M. 1601 32. Registral's Signature 31. Date filed (Month, Day, Year)

OCT 2 5 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 11:50 2011 OCTOBER Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Sinai Hospital of Buttimore Battimore 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral Days Hours Min (Month, Day, Year) 1 € M 2 □ F **Director** 45 Usual Residence of Decedent 28a-f show and Mental Hygiene.
and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f shov
is marked other than "natural", or items 23a or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 No MOCO 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Sweetwine, Alburt Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the leap Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date ţ 4 ☐ Donation 5 ☐ Other (Specify) o Funeral Service Licensee 21. Signati Home 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ END-Stage LIVER DISEASE. 20 days disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of, Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 5 Other (specify) ☐ Pregnant at time of death ☐ Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hepatitis C, alcohol abuse, ileus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours and occur.

To the Funeral Director: After t Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending iniury 1X Natural 5 Pending work 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the Set of my knowledge 29d. Date signed (Month, Day, Year,

29b. Signature and title of certifie RES 000 OCTOBER 22,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Airen Pan, Mo Sinai Hospital of Battimore, 2401 W. Belveberg Ave. BaltIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

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21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 23a per dr.,g920,10/21/2011dhb,25

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charles Marshall Scott 2011 October 11 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Hours 234-18-7861 Director 89 Apr. 14, 1922 West Virginia Usual Residence of Decede Director 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits 28a-f MD Prince George's Bowie XX Yes 2 No o 10e Street and Number 10g. Citizen of What Country? pe Funeral 23a 12904 Beaverdale Lane 20715 U.S.A. Page 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. i "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1XXYes 2 No
If Yes, Give Air Force
Year or Date Air Force þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify Completed 3 Divorced 4 Divorced White lith and Mental Hygiene. 27 is marked other than "natur r traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) U.S. Government Elementary/Secondary (0-12) College (1-4 or 5+) Procurement Executive 5+ Printing Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Bruce Scott Isabel Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty F. Scott - Wife Department of Health Important: If item 23 any injury or other to once. 12904 Beaverdale Lane, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cometery crematory or other place)
HOLY Trinity
Piscopal Church Co Rurial 2 Cremation 3 Removal from State 10-15-2011 5 Other (Specify) Bowie, MD Cemeter 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, MD 20715 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final 20 hours Physician/ traceretra disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Hypertensive Atherosclerotic Cardiovascular Disease Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): use as the burial-transit CERTIFICATION APPROVED BY MEDICAL and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Division of Vital Records, P.O. Box 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year signed by the at d be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' 2 🖰 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 11116 ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral (27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending Natural 5 Pending 1 Yes 2 No Accident Investigation **Director:** 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c License number

Registrar
DHMH 17 Rev 06-2011

State

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Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

filed (Month, Day, Year,

00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 31 2011 October Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore HOSPITAL andalls town 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Months 1072971922 **Director** 215-14-9028 88 Usual Residence of Decedent 28a-f shov 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1840 REISTERSTOWN ROAD 21208 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian rmed Forces Black, White, etc. ģ 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 XWidowed 4 ☐ Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 BOOKKEEPER PEPSI CORP. other traumatic event, Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic to SIMON SAPPERSTEIN SOPHIE SMELKINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2804 LAURELWOOD COURT, BALTIMORE, MD MARCIE JEFFERS/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) SHAAREI ZION CEM. 10/23/2011 4 Donation 5 Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., 5 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Sepsis Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** neu monia Sequentially list conditions cause. Enter Underlying Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No the 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? certificate 1 ☐ Yes 2 ☑ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 4 No Other: Certificate: To 1 Impatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier з 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D65843 october, 21, 2011

State Registrar 401 Old Court Road, Randallstown, HD 21133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Abdallah Ke 31. Date filed (Month, Day, Year) OCT 2 5 2011

Brandon	Michael	Sisler

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				nartment						

	1	1- For State Registrar			Reg. No. 2011 3								
Physicia Medical Exami	an/	Decedent's Name (First, Midd		-			2. Date of Deal Month October 1	Day Year	3. Time of Death 1032 hrs				
nedicai Exaiiii		Brandor 4a. Facility Name (if not instituti	n Michael Sison, give street and number)		4b. City, T								
		502 Ashbury Lane			Sever	rna Park		Anne Arundel					
Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last bi	irthday) If Unde	er 1 Year If Under	24Hrs. 8. Date of Bir Min.		I. Birthplace (State or oreign				
Director		214-39-1671	1 X M 2 F	18	Yrs.	S Days Hours	05-07		Country) Maryland				
Ąt	F	Usual Residence of Decedent 10a, State 10b, County		10c, City, Tow	n or Location				10d, Inside City Limits				
P 401			Arunde1			Severna	Park		1 Yes 2 No				
Maryland 28a-f show any d at once.	Director	10e. Street and Number	Arunder		10f. Zip			0g. Citizen of What	Country?				
the M		43 Baldy Aver	nue			21146		United	States				
0036 within 72 hours after death with the Maryland join. her than "natural", or items 23a or 28a-f sh. Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2	12. Was Decedent Armed Forces?			ent of Hispanic Origin fy Cuban, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	14, Race - A White, e	merican Indian, Black, tc.				
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within iene.	E C		111		Stud		Name (First, Middle, I		ation				
P 2 2 2 4	BeC	17. Father's Name (First, Middle Michael Will					ca Dyan Fai						
D 2121: should be fil and Mental I 7 is marked		19a. Informant's Name/Relation		1:	9b. Mailing Address		per or Rural Route Nur		State, Zip Code)				
imore, MD 2 Pages 1 and 2 shou ment of Health and N tant: If item 27 is n or other traumatic		Laura D. Sisle	r / Mother		43 Baldy	Avenue Se	everna Parl	k, Maryla	nd_21146				
ore, ML es 1 and 2 s of Health a of Heath a fritem 27		20a. Method of Disposition 1 X Burial 2 Crematic	n 3 Removal from St		of Disposition (Nar atory or other place)		Date	20c. Location - Ci	ty or Town, State				
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other to		4 Donation 5 Other S	Specify:				10-21-2011	Elkridge	e, Maryland				
Baltimore permit. Pages 1 Department of F. Important: If i		21. Signature of Funeral Service	Chsensee	,	Dona1d	Address of Facility	al Home &	Crematory	y, P.A.				
Physician	-1	23a. Part I, Enter the disease, o	r complications that caused	the death, Do i	not enter the mode	Innapolls of dying, such as ca	Road Odent rdiac or respiratory arr	rest, shock, or heart	Approximate Interval				
Medical	1	— flaflure. List only one caus Immediate Cause (Final diseas	W-aladana	and al	lochol Int	toxication	n		Between Onset and Death				
Examiner		or condition resulting in death)	Due to (or as a cons										
	<u>,</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence of):									
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red Insit	Examiner	events resulting in death) Last	Due to (or as a cons	equence of):									
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760, cate be physic he bur		IF FEMALE:	23c. If yes, outcome	ne of pregnanc	У			23d. Date of de					
ox 687 eath certific attending for use as t	ian	23b. Was decedent pregnant in past 12 months?	I LIVE DITTI	time of death	2 Fetal death 5 Other (Spe	_	pregnancy	Month	Day Year				
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Division of Vital Records, P.O. ral or Atteodiog Physician: The law requires that the star death. **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detac.	Certification:	3 Suicide 6 X Co	uld not be 28e. Place of Ir		farm, street, factory	y, office building, etc	. 28f. Location (or Town, S	Street and Number of State) 502 As	or Rural Route Number, City hbury Lane.				
Ospital ospital hours a noeral I		4 Homicide				a time, data and place	Severna	a Park,Md.	•				
Division of Vital Records, P.O. Box 68760, To the Hospital or Atteodiog Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fuorral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	(Check only	Physician: To the best of maminer: On the basis of exa										
To vit	Me	29b. Signature and title of certif	and manner stated		29	c. License number		29d. Date signed	(Month, Day, Year)				
(A)		(tm. 21			O.C.M.E.		October 16, 2	2011				
		30. Name and address of person	on who completed cause of c puty Chief Medical E			ore Street Ralli	more MD 21223						
	tate			xammer s									
S Regis		31. Date filed (Mosth Day, Yea	5 2011 Sense	m B.	parke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 Per INF G920 10/26/2011 JH
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 Date of Death

			For State Registrar		State of W	ai yiaii			te of L		TIVICITIATI	Reg.	No. 201	1 3	3930
	Physicia	n/	1. Decedent's Name (First, Paul Eri		Spruill						2. Date of Month 10		2011		ne of Death
· .	Medic Examin							4b. Cit	y, Town, or	r Location of Dea			4c. County of Dea		0.10A
med		•	Prince Geor	ge's	Hospital (Cente	er	Che	neverly Prince Go					eorge	's
	Funeral Director		^{5.} 245		Sex 7. Ag ★ M 2 □ F 6:		ast birthday) Yrs.	If Und Months	ler 1 Year s Days	If Under 24 Hi Hours Mi		Birth Day, Yea 1	9. Bi	rthplace (St ountry) N	ate or Foreign
	ind show at	١	Usual Residence of Deceder 10a. State 10b. C			10c. Cit	y, Town or Lo	cation						10d. Insid	de City Limits
	Maryla 8a-f s tified	Director	MD Pri	nce (George's	Воъ	vie							11	Yes 2 ☐ No
	a or 2 be no		10e. Street and Number				-		Zip Code	-			Citizen of What C	ountry?	
	th with ms 23 must	Funeral	2161 Vittor	ia Co					20721		0 -: 5 - 1/ 1	US			
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status1 ☐ Never Married 2 [3 ☐ Widowed 4 X Di		12. Was Decedent Armed Forces? 1 Yes 2 4 If Yes, Give Year or Dates.					lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or Nerto Rican, etc.)	10-	14. Race - Ame Black, Whit Specify: B1	te, etc.	ın, _
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102	iled w Il Hygi othe	Be	17. Father's Name (First, Ma	ddle, Last)	т						ame (First, Midd	lle, Maide	en Surname)		
ylar	d be f Menta arked atic e	မ	Paul McKe	ver						Lucind	a Sprui	11			
Mar	12 should be file lith and Mental F 27 is marked o r traumatic eve		19a. Informant's Name/Rel		0	nter							or Town, State, Zgton, DC		02
re, I	1 and 2 of Healt item 2		Johnaa A. Spi				Place of Disponentery, cre	osition (N	ame of		Date	_	Location - City o		
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other		1 Donation 5 C	ther (Spec	ify)		. Linc	o1n	Cemet	ery 10/			entwood,		
Bai	Depar Depar Impor any ir		21. Signature of Funeral Se	rvice Licen	ndesen								ch Funer DC 20011		ome
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-	Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Aleno Carcino ma Metastatic Adeno Carcino ma Due to (or as a consequence of): Brain Metus tasis										1 4	/r.		
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Division of Vital Records,	The law require ate has been s page 2 should	Completed									p	utopsy erformed	prior to death?	completion	lings available n of cause of
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Vit	Physician: this certific ral director,	고 E	examiner? 1 Yes 2 No				ER/Outpatie	ent 3 🗆	DOA Oth	ner: 4 🏻 Nursing	Home 5□R	esidence	6 Other (Spe	cify)	
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sion	Attending or death. sctor: After by the fune	Certificate	3 Suicide 6 🗆	nvestigatio Could not l determined	be 28e. Place of Inj	ury - At ho	ome, farm, st	M reet, facto		res 2 🗆 No			and Number or R	ural Route	Number,
Div	Hospital or 24 hours afte Funeral Dire				L							Town, St			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 I Me	dical Exan	ysician: To the best of niner: On the basis of e rse Practioner: To the	examinatio	n and/or inve	stigation,	in my opini	ion, death occurre	ed at the time, da	te and pla	ace, and due to the	e cause(s) ar	nd manner stated
	To the within 2 To the comple				//							1			ar)
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D			29b. Signature and title of the second secon	erson who	completed cause of c	leath (Iten	n 23a) (Type, 2150	Print) Auna	poli	s Rd 6	ienn D	rle	MD 2	769	9 .
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Swisher George Donald 7:30 A M October 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Severn Anne Arundel Co. Watts Group Assisted Living Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 207-03-6020 **Director** 1 X M 2 □ F 92 Aug. 11, 1919 Pennsylvania Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location Director must be notified Anne Arundel Co. 1 Yes 2 No MD Severn 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 7800 Elberta Drive 21144 items death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No WWII If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Examiner Black, White, etc ō by 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify "natural" 3 X Widowed 4 Divorced Specify: Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Electrical Elementary/Secondary (0-12) College (1-4 or 5+) Contractor yrs. Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alta Sweigart George Η. Swisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Severn, Maryland Mrs. Carole J. Binney / Daughtet 7800 Elberta Dr. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/27/2011 Compass, PA John's Episcopal Cem. 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Sa Services, PA; 1 2nd Ave. SW; Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Ponset and Death shock, or heart failure. List only one Immediate Cause (Final Ph_sician/ Vegr disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death
Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 10 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 410 잍 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending iniury thin 24 hours after death.

the Funeral Director: Aft
mpletely filled in by the fu 1 Yes 2 🗌 No Investigation 2 Accident Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 To the within 2
To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo nave 8 31. Date filed (Month, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 33932 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 19, 2019 DOLORES MARIE SHUPE 9:32 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE BALTIMORE TOWSON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Days Hours 10/11/1930 MARYLAND Director 218-26-5713 1 □ M 2**X** F 81 Usual Residence of Decedent show 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f MD BALTIMORE MIDDLE RIVER 1 Yes 2X No ms 23a or must be r 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 3539 DAHLIA LANE 21220 USA items 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give ö þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE "natural" Completed 3XXWidowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the SECRETARY CLERICAL alth and Mental Hygie

27 is marked other

r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) : Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked or ပ FRANK RYER JULIA ANN KEYS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEFFREY R. HAUBERT (NEPHEW) 3522 DAHLIA LANE, MIDDLE RIVER, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ò 1

Burial 2

Cremation 3

Removal from State Department of Important: If any injury or once. 4 Dopation 5 Other (Specify) ATLANTIC CREMATORY 10/20/2011 GLEN BURNIE, MD 22. Name and Address of Facility CHARLES S. ZEILER & SON , INC Signat of Funeral 6224 EASTERN AVE BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Duel o (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical P.O. Box 68760 as 1 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy ģ Hospital or Attending Physician; The law requires that the death in the past 12 mg/ths? Day 5 Other (specify) Month Year Pregnant at time of death No Yes detached 9 Unknown Unknown signed by till Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy perforn Yes 2 X No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 100 Other: ᅆ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of De vi Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined after 24 hours Funeral Medical

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State

completely the

2

29a. Certifier

only one)

29b. Signature as

3 [

d_title of certifier

Registrar

who completed cause of death (Item 23a) (Type, Print)

Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oct. John Barry Trombetta 19 2011 10:40P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 39 West Deep Run Road Westminster Carroll Co. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) June 17,1938 Davs Hours 216-34-6759 **Director** 1 XM 2 □ F 73 Yrs. Maryland Usual Residence of Deceder 28a-f show 10a. State 10d, Inside City Limits notified at 10c. City. Town or Location Director Westminster 1 Yes 2 No Carrol1 MD 10f. Zip Code 10e. Street and Number ō 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 21158 39 West Deep Run Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other th Department Store <u>Salesperson</u> 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sophie Vatapsky other traumatic Michael Trombetta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ige 1 and 2 st nt of Health a t: If item 27 is 21158 Mrs. Rose Marie Trombetta (Wife) 39 West Deep Run Road Westminster, MD Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or oth cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gdns. 10/22/2011 Middle River, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Ave. Dundalk. Maryland Wise 20a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 🗌 Unknown P.O. signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> BRTENSION Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? this certificate 2 🗆 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2-No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 1 Natural within 24 hours after use.....

To the Funeral Director: After the funeral by the funeral by the funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral fun 5 Pending work? Accident
Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Roger Alexandre Testud Physician/ O Ctober 7:20 PM Medical Name (if not institution, give street and number, Town, or Location of Death **Examiner** 4c. County of Death saltimore 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 81 Months Hours Min. (Month, Day, Year) France 215-98-1814 1930 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 504 Charing Cross Rd. 21229 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🔼 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baker Bakery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Roger Testud Marie Rose Olivetti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mireille Testud /Wife 504 Charing Cross Rd. Baltimore, MD 21229 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date Oct 25 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 2011 4 Donation 5 Other (Specify) 22. Nam@remarkisonFaaind Funeral Alternatives 21. Signature of Funeral Service License 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between nset and Death Immediate Cause (Final Physician/ oronar disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to o been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? encephalopathi 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 performed 1 Tyes 2 Tho Yes 2 1 Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: |@ 1 Unpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number amou m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year,

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month October 24, Year 2011 Physician/ 2:38 PM Josephine Ann Thomas Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 94 (Month, Day, Year) **Mar** 08, New York 100-18-8122 Director 1917 1 🗆 M 2 💢 F Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 205 E. Joppa Rd. Apt. 1002 21286 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Hygiene. If Yes. Give 3 Widowed 4 Divorced White Year or Dates. injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home marked other Be 17. Father's Name (First, Middle, Last) Department of Health and Mental Fine Important: If item 27 is marked any injury or net 18. Mother's Name (First, Middle, Maiden Surname) 2 Salvatore Brunc Sarah Ann Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Thomas /Son 2122 Pink Flamingo Lane Tallahassee, FL 32308 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Oct cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 4 Donation 5 Other (Specify) Chesapeake Crematory 2011 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee MO1585 helpocce 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 1015 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): sician and burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as IF FEMALE igned by the attendin be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year Pregnant at time of death Dav 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director; After this certificate has b autopsy perform Yes 2 XNo 2 🗌 No 1 🗌 Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 욘 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕅 Other (Specify) V Ø 🛇 🗸 Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Natural → atural

Accident

Suic 5 Pending 1 Yes 2 No the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 29b. Signature and title of certifie TOBER 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N Charles ST TONSON AND HARL LS MO C-701 31. Date filed (Month, Day, Year, State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month To DCV nn 00mer nie Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins N/A Balk more HOSPItal CiIf Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 240-283 **Funeral** Days (Month, Day, Year) Hours **Director** 1 □**X**M 2 □ F 05/12/1925 Carolina 86 Ν. 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 701 N. 21205 U.S.A. Streeper St. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, was becedent Ever Armed Forces? 1 🔀 Yes 2 🗌 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation Beth Pensembustry (Specify only highest grade completed) (Give kind of work done during most of working 72 al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Steel Labor 12th Grade other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) should be file and Mental H ၉ Clarence Toomer Nora Lasater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 701 N. Streeper St., Baltimore, MD 21205 Paulette Toomer(daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 10/28/11 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fundal Service Licens 30 sephodis of Brown Jr. Funeral Home 21217 2140 N. Fulton Ave., Baltimore, MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final word Enysician/ disease or condition Medical resulting in death) **Examiner** ension quantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (g Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by t d be detact Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? this certificate 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2X ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 4 hours after death. •uneral Director: After thely filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours after

To the Funeral Direc

completely filled in by Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOSEPH. 0707 M TAYLOR Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY OF MARYLAND MEDICAL SYSTEM BALTIMORE **Funeral** Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 - F 3-54-713 Months Days Hours th, Day, Director Carolina Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Completed by Funeral Director 10d. Inside City Limits 1 Yes 2 No timo 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Mary land conday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last, Mother's Name (First, Middle, Maidelt မ 19a. Informant's Name/Relationship (Type, Print) (Bother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other tran 20a. Method of Dispos 20b. Place of Disposition (Name of cemetery, crematory or other Date 20c. Location - City or Town, State Department of 1 Burial 2 Cremation 3 Removal from State 4 Donati 5 Other (Specify) Signat Service Licenses Part 1. Fitter the alsease, or complications that caused shock, or heart failure. List only one cause on each line isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Ischemic Medical Examiner 5 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atter detached for u 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🗌 No Yes 2 X No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred **X** Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier John My MD 1104115943 10,19,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RANI/22 SOUTH GREENE STREET/BALTIMORE/MD/21201

DHMH 17 Rev 7/2009

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 33938 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **EVELYN** TUNE Modh 201^Y1ar 4:15 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOSEPH RICHEY HOSPICE BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 69 217-40-0379 Director 1-21-1941 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director MD BALTIMORE 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2525 EUTAW PLACE 21217 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1X Never Married 2 Married Baltimore, Maryland 21215-0036 **BLACK** 1 ☐ Yes 2 X No Specify: Specify. 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) event, the 9 HOMEMAKER HOME permit. Page 1 and 2 should be filed wii Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, <u>tit</u> <u>onee.</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ MARY DANIELS JAMES LEE TUNE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1906 RUXTON AVE., BALTO., MD 21216 CURTIS SMITH/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 1 v Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State cemetery, crematory or other place) 10/26/11 BALTIMORE, MD Donation 5 Other (Specify) ZION 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC <u> 1701 LAURENS ST., BALTO., MD 21217</u> 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure, List only one cause on each line Onset and Death Immediate Cause (Final Physician/ hepatorellular disease or condition resulting in death) years Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ encephalopathy, diabetes mellitus on Insulin Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? hypertension, Chronic renal failure 24a. Was an autopsy performed? 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 No ပု 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 105016 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending Accident M 1 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a

To the Funeral D

completed filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

Registrar

State

4:15am

DHMH 17 Rev 7/2009

Campbell Blud, Svite 200

npleted cause of death (Item 23a) (Type, Print)

Macdonald

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Month OC7 TAYLOR 5-30 PM JANIE 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Ellicott City Healthcare Rehab Ellicott City Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)
 TT A **Funeral** Min. 1926 V A Director 579-36-1654 85 Usual Residence of Decedent or 28a-f show 10a. State 10c. City. Town or Location any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Directo 1XXYes 2 ☐ No MD Howard Columbia 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21045 USA 6315 Red Haven Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 🕅 Never Married 2 🗌 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Black "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 t h College (1-4 or 5+) Food Service Manager Private Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lynn Taylor Sadie Calloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Taylor/son 6315 Red Haven Rd.,Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cem. 10-21-2011 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 20746 22. Name and Address of Facility Cedar Hill FH, 4111 PA Ave., Suitland, MD a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CEREBROVASCULAR disease or condition resulting in death) month Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Dav Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Peripheral Voscular Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 **N**o ္ဝ Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manyer of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 \square Pending 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

STUDK MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Dep	artment of Health and I	Mental Hygiene	
			rtificate of Death	Reg. No. 2	011 33940
Dharini	· /	1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death Year
Physic Med		CORY DAISY HAMPTON TAYLOR		10-12-2811	10:58 P ^M
Exami	iner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		of Death ce George's
Funana		St. Thomas More Rehab. Center [5. Social Security Number	Hyattsville If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
Funera Directo		577-52-0379 1 M 2 TF 81 Yrs.	Months Days Hours Min.	07-04-1930	Country) SC
F ow	٦.	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Le			40.1.2.1.02.1.22
ryland I-fsh ieda	cto	10a. State 10b. County 10c. City, Town or Li	cation		10d. Inside City Limits 11√2 Yes 2 □ No
ne Ma or 28g	Director	MD Prince George's Laurel 10e. Street and Number	10f. Zip Code	10g. Citizen of V	
with t	Funeral	8224 Harvest Bend Lane, #23	20707	USA	·
leath items er mi	Ē	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	e - American Indian,
after c	ē	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 No Specify:		k, White, etc. Black
fild K IK IS-DOOO filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Completed	3 A Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education 16a. Dece	dent's Usual Occupation		usiness Industry
A 72 h	ם	(Specify only highest grade completed) (Give Elementary/Seconday (0-12) College (1-4 or 5+)	kind of work done during most of work OO NOT use retired)	king	
withir giene giene rth		Elementary/Seconday (0-12) College (1-4 or 5+) Home	emaker	Own Ho	ome
afiled tall Hy ed out	To Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Surname	*)
should be filed within and Mental Hygiene, and Mental Hygiene, is marked other than raumatic event, the I	-	Tally Hampton		Childs	
2 ± 2 ±			ng Address (Street and Number or Rui Harvest Bend		
I and I heal item		20a. Method of Disposition 20b. Place of Disp	osition (Name of		City or Town, State
Dallillor Demit. Page 1 Department of mportant: If it any injury or o		1	matory or other place) con Natl. 10-1	9-2011 Suit1a	and, MD
Daltillo permit. Page Department (Important: If any injury or once.		21. Signature Fineral Service Licensee	2. Name and Address of Facility	11 DA A C.	20746
		we forth	edar Hill FH,41		uitland, MD
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
Physician _ Medica		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Due to (or as a consequence of):	<u>Cardiovascula</u>	r Disease	CHOCK ENG DOLLIT
Examine					
	iner	Sequentially list conditions, If any healing Lummedian cause. Enter Underlying			
cuted nd ransit	Examiner	Cause (Disease or linjury that initiated events C	***		
te be executed nysician and he burial-transit	ical E	resulting in death) Last Due to (or as a consequence of):			
Date b	edic	d			
certifile nding use as	N.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	7	23d. Da	te of delivery
death e atte	Physician/Med	in the past 12 months? 1	Control of the contr	Mo	nth Day Year
t the c	Phy	9 Unknown	underhing appearing Doch I	00 81444	ribute to the cause of death?
requires that the death certificate I requires that the death certificate I been signed by the attending phys should be detached for use as the	2	Tarti. Stici significant solicitoris solicitoris de decar set not locating in the	undenying cause given in Fart i.		3 ☐ Probably 4X Unknown
aw requires as been sig 2 should b	Completed				Were autopsy findings available
e law e has l	J m			autopsy performed?	orior to completion of cause of death?
an: Th tificate or, pa	Be Co		26. Place of Death (Chec		1 L Yes 2 L No
ysicia ysicia nis cer direct	PB B	examiner? 1 Yes 2 XNo Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 X Nursing H	ome 5 Residence 6 Othe	er (Specify)
or Attending Physician: The law after death. Director: After this certificate has in by the funeral director, page 2:		27. Manner of Death 1 X Natural 5 ☐ Pending (Month, Day, Year) 28b. Time of (Month, Day, Year) injury		28d. Describe how injury occurre	
ttendi death. tor: A	Certificate:	2 Accident Investigation	M 1 Tyes 2 No	000 1 11 10 10 1 1 1 1 1 1	Devel Devel Newstern
or Al after after Direction by	Sed	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	геет, тастогу, опісе	28f. Location (Street and Number City or Town, State)	er or Rurai Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	edical	29a. Certifier 1: Certifying Physician: To the best of my knowledge, death			
the Ho nin 24 the Fu	Mec	(Check 2: Medical Examiner: On the basis of examination and/or invenience only one) 3 Certifying Nurse Practioner: To the best of my knowledge	death occurred at the time, date and pla	ce, and due to the cause(s) and ma	anner as stated.
Vitt To 1		29b. Signature and title of certifier	29c. License number		d (Month, Day, Year)
MIN		- Cometinell ser	00.11	Cur	413,2011
J.M.		30. Name and address of person who completed cause of death (Item 23a) (Type, Paul Devore, MD, 4203 Queensbury		11e, MD 2078	1
St	ate	31. Date filed (Month, Den Year) 32. Registrar's Signature	, , ====		
Regist	trar	OPI WA CALL DOWN			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $0^{\text{Month}} 24 - 20^{\text{My}} 11$ 18:53 PM ROSALIE BELL THURMAN Medical 4b. City, Town, or Location of Death Clinton 4a. Facility Name (if not institution, give street and number) **Examiner** Prince George's Southern Maryland Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) V A Months Days Hours Min 1 M 2 V 225-24-9880 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No |Prince George's Forestville MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 20747 USA 5639 Rockquarry Terrace 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural", Completed 3X Widowed 4 □ Divorced other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Accounts Payable Clerk Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of (Unav.) ည Annie John Bell permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State Zio Code, S639 Rockquarry Terrace, Forestville, MD 20747 19a. Informant's Name/Relationship (Type, Print) Priscilla Debnam/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Riverdale Pk. Crem10-10-2011 1
Burial 2
Cremation 3
Removal from State Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 20746 22. Name and Address of Facility Cedar Hill FH,4111 PA Ave.,Suitland, MD Part 1. Enter the disection of the Part 1. Enter the disection of the Part 1. r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. List only one Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine as a consequence of) and I-transit The law requires that the death certificate be executed Due to for as a consequence of resulting in death) Last physician a sthe burial-Medical Box 68760 attending ph IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown Division of Vital Records, P.O. ed by tl detach signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy r this certificate has eral director, page 2 perforn 2 No Yes 2 No 1 Yes To the Hospital or Attending Physician: : After this certific stuneral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 은 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 9-24-

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 20 20 1 Physician/ 2.15A ELVA MAY THOMPSON OCTOBER Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BACTIMORE WASHINGTON MENLAL AMNE GLEN BURNIE If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Sept 29, 1941 1 M 2 👿 F Yrs. Director 214-38-8164 70 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Pasadena Maryland Anne Arundel 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21122 305 Sharon Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ "natural", or 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: White Specify. 3 Divorced 4 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Child Care 0 Kindercare Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anna Grizen Howard Weisman other traumatic 140m750N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Landis B. Thompson, Jr. (Husband) 305 Sharon Drive, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 10/24/2011 Glen Burnie, Maryland Atlantic Crematory, LLC 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. Kevin E Ecker 3204 Mountain Road, Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final PREAST Physician/ NIETASTA disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No ⊥ γαι ∐ Yes ∏ II-Day Month Year Pregnant at time of death signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manuar of Death 28b. Time of 28c. Injury at work?
1
Yes Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 24 hours after death. Funeral Director: A 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: / Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1ABA Date filed (Month, Day, Year) 32. Regist State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 18 35PM Melvin Russell Terry, Jr. OCTOBER 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMOLE WASHINGTON MEDICAL BURNIE ARUNDEL GLEN ANNE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🙀 M 2 🗆 F November 20, 1969 Maryland **Director** 214-96-2873 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 ¥ Yes 2 ☐ No York Pennsylvania York ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 900 East Princess Street 17403 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 ☐ Never Married 2 🙀 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. Specify: 3 Divorced 4 Divorced **Black** Completed Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) FedEx 12 TERRY, MELVIN Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wilma D. Wilkins Melvin Russell Terry, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 East Princess Street, York, Pennsylvania 17403 Angela Marie Terry/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Our Lady of the Fields Cemetery 20c. Location - City or Town, State October 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2011 Millersville, Maryland 21. Signature of Fun I Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 MO1386 Enforthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final A3PILADION Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to or as a cons To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Pregnant at time of death Yes 2 No 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 No 1 🗌 Yes Yes 25. Was case referred to medical completed filled in by the fureral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier OCTO BER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MWIGAL ASHINGSON 31. Date filed (Month, Day, Year) 32. Registrar' Signatu State

Registrar

Physicia	n/	1. Decedent's Name (First, Middle, L William Christo	,				2. Date of Death	19, 2011	3. Time of Death 8:17 A.		
Medic		4a. Facility Name (if not institution, gi	+		4h City Town or	Location of Death	OCTODET	4c. County of Dea			
Examin	er	Upper Chesapeak		or	Bel Ai			Harford			
°Funeral	-		Sex 7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	B. Date of Birth		thplace (State or Forei		
Director		056-36-6369 Usual Residence of Decedent	1 □3M 2 □ F 68	Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day, Young) Mar. 2,	1943	New Yor		
and show	호	10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limi		
Mary 28a-f otifie	irec	Maryland Harf	ord I	Bel Air					1X Yes 2:		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?		
ath wi	nue	409 Webster St.	12. Was Decedent Ever in U	S 113.1	21014	ispanic Origin? (Speci	fy Yes or No-	USA 14. Race - Ame	oricon Indian		
or ite	by F	1 Never Married 2 XMarried	Armed Forces?	.0.	f Yes, specify Cuba	n, Mexican, Puerto Ri	can, etc.)	Black, Whit			
rs afte rral", Exar	ed b	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.		Yes 2 No	Specify:		Specify: Whi	te		
2 hou "natu	Completed	15. Decedent's (Specify only highest		16a. Dece	dent's Usual Occup	ation duning most of working	. 16	6b. Kind of Business			
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ould I		19a. Informant's Name/Relationship		10h Mailir	on Address (Street	and Number or Rural F			in Code)		
12 sh alth ar 27 is r trau	l	Mary Tobiason /	Wife			Street, Be					
1 and f Hea item othe		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of	Da		Oc. Location - City or			
age lent o nt: If		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			natory or other place ervice Co		4/2011	Towson, M	Marvland		
mit. F partm porta / inju		21. Signiture of Fyn ral Sergice ice				ss of Facility McC					
a in De	- 1	alrell 4n	eu L	5	0 W. Broa	adway, Bel	Air, Ma	aryland 21	•		
Physician Medical Examiner		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to ur as a consec	ble.	myoc	andid	inface		Interval Between Onset and Death		
ite be executed hysician and he burial-transit	dical Examiner	Sequentially list conditions, it all, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last	c. Due to (or as a consec								
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. with 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the	_	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 Live Birth 2 Fei 4 Pregnant at time of 9 Unknown	tal death 3 🛚	Ectopic pregnanc Other (specify)	sy		23d. Date of de Month	elivery Day Year		
uires that t n signed b ild be deta	b	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause giv	ven in Part I.			o the cause of death? Probably 4X Unkn		
aw requas bee	Completed						24a. Was an autopsy	24b. Were au	utopsy findings availal completion of cause		
The la	ν						performe	ed? death?	s 2 🗆 No		
stan: ertific ctor,	Be (25. Was case referred to medical examiner?				ace of Death (Check o	nly one)				
hysic his ce Il dire	은	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☑		t 3 DOA Othe	er: 4 🗌 Nursing Hom	e 5 Residen	ce 6 Other (Spe	cify)		
ath. r: After t	Certificate:			28b. Time of injury	28c. Injury work M 1 🗆	?	d. Describe how	injury occurred			
or Atte after de Directo in by th											
ra led	al Cert		29a. Certifier (Check (Check 1								
the Hospital thin 24 hours the Funeral mpleted filled	Medical Cert	(Check 2 L Medical Exa	miner: On the basis of examination	on and/or inves	29c. License	e time, data endiplace,	and due to the re	place, and due to the	cause(s) and manner s		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death Reg. No. 20	3394
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Ashley Vest 2. Date of Death Month Day Year October 16, 2011	3. Time of Death 1921 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Washington Medical Center Glen Burnie 4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 215-29-8971 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min. April 5 1988	
215 be file ntal Hy rked o	10a. State 10b. County 10c. City, Town or Location 10f. Zip Code 10g. Citizen of What Count 10g. Citizen of What Count 10g. Citizen 10g. Citizen 10g. Citiz	10d. Inside City Limits 1 Yes 2 No ry? an Indian, Black, te dustry
Baltimore, Michael Baltimore, Michael Bermin O'Health Department of Health Inportant: If item 2: iojury or other fraum	Michelle Reils-Mother 20a. Method of Disposition 1	own, State Maryland of Lansdow
wecuted n and - transit cal Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. First Underlying Cause (Disease or injury that initiated events resulting in death) Last Last UNPENDED AMENDED 23a, 27, 28a-f, per me, g920 10-26-11 sm	Between Onset and Death
cords, P.O. Box 687 Iaw requires that the death certific has been signed by the attending p 2. should be detached for use as th npleted by Physician/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown Part II. Other significant conditions 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 9 Unknown 23d. Date of delivery Month Da 23d. Date of delivery Month Da 23d. Date of delivery 2 No 1 Pregnant at time of death 5 Other (Specify) 9 Unknown 23d. Date of delivery 23d. Dat	ne cause of death? bly 4 Unknown psy findings available impletion of cause of
Division of Vital F pital or Atteodiog Physiclas: para sher death. eral Director: After this certific filled in by the funeral director; Pertification: To Be C	25. Was case referred to medical examiner? 1	al Route Number, City
	29b. Signature and title of certifier 29c. License number O.C.M.E. October 17, 2011 30. Name and address of person who completed cause of death (Item 23a)	h, Day, Year)
OV	Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 001 32. egistrar's Signaturi	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:21 PM OAN WEJNER OCTOBER Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HARBOR HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2**X** F Months Days Hours December 11, 1932 78 Yrs. **Director** Pennsylvania 168-26-6183 Usual Residence of Deceden 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 28a-f Anne Arundel Odenton 1 Yes 2x No Maryland 10e. Street and Number ō 10f. Zin Code 10g. Citizen of What Country? be Funeral 23a with 1312 Tenbrook Road United States 21113 permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give White 1 Yes 2 No Specify 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Officer Worker Banking Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Henry Shick Esther Harbison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth C. Brettell/Son 1312 Tenbrook Road, Odenton, Maryland 21113 20a. Method of Disposition 20b. Place of Disposition (Name o 20c. Location - City or Town, State October 24 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State west Arundel 4 ☐ Donation 5 ☐ Other (Specify) 2011 Odenton, Maryland Crematory 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road, Odenton, Maryland 21113 of Funeral Service License MO1386 e disease or co plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, he cause on each line. 23a, Part Approximate Interval Between Immediate Cause (Onset and Death Ph. sician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or linjury and -tran that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Second at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day ed by the a g Unknown g 🗌 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RESPIRATORY FAILURE, PNEUMONIA 1 Yes 2 No 3 Probably 4 Unknown RENAL FAILURE, DIABETES, ASTHMA 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? Yes 2 No or Attending Physician: 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Hospita Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) s after death. Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No M Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a the Hospital Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

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21215-0036

P.O. Box 68760

Division of Vital Records,

31. Date filed (Month, Day, Year)

SUSAN

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GEORGE

201

32. Registrar's Signature

son who completed cause of death (Item 23a) (Type, Print)

3001 SOUTH HANDVER STREET

RES OOI

29d. Date signed (Month. Day, Year)

2011

OCTOBER 22

BALTIMORE, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 33947 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:03 AM DOTOBEL Ella L. Winfield Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Sinai Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours 244-56-1917 **Director** 1 🗆 M 2 😿 F 76 5/25/1935 N.C. or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A 1 X Yes 2 No Baltimore 10e. Street and: Numbe 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 5320 The Alameda 21239 USA 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black "natural" Completed 3 ₩ Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Dietician Hospital Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Latham Wallace Pennina Coward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Brian Winfield-Son 5320 The Alameda Baltimore, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 10/26/2011OwingsMills, MD 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Ent. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Opset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Huger ten Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician the for use as the buris Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 XNo Hospital Other: 은 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of erson who completed cause of death (Item 23a) (Type, Print) 4940 EASTERA Registrar

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			Registrar 1. Decedent's Name (First, Manual Control of the Contro	tiddle I ast)			Cer	tificate	e of D	eath		O Data of Da	Reg. N	10. 2		3394
	Physicia Medi				Ronald		ce Wi	1ey				2. Date of De Month Oct.		3, 2	Year 2011	3. Time of Death
a	Examir	ner	4a. Facility Name (if not instit			•		4b. City,		Location of	of Death		4	c. County		
	Funeral	_	Stella Maris 5. Social Security Number	Hosp 6. Sex		er Age (In yrs. la	ast birthday)	If Under		nium If Under	24 Hrs.	8. Date of Bir	th	Ba		ore Co.
В	Director		219-52-9075	11] M 2 □ F		Yrs.	Months	Days	Hours	Min.	(Month, Da	ay, Year)		Coun	itry)
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	or 28 e noti	Funeral Director	10e. Street and Number					10f. Zip	Code			T	10g. C	Citizen of V	What Coun	
	with s 23a ust b	eral	2007 Jasm:	ine Ro	ad				212	222			U	nite	d Sta	ites
21215-0036	ie 1 and 2 should be filed within 72 hours after death with the Maryland tof Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2X 3 □ Widowed 4 □ Divi	Married	12. Was Deceder Armed Forces 1 X Yes 2 If Yes, Give Year or Dates	s? □ No	1	Vas Deced f Yes, spec	ify Cubar	n, Mexican	, Puerto	cify Yes or No- Rican, etc.)		14. Race	e - Americ ck, White, e	an Indian,
2-0	hours natur dical I	lete	15. De	edent's Edu	cation	vieti	16a. Decec						16b.	Kind of Bu		
21	nin 72 ne. Ihan " e Med	Completed	(Specify only Elementary/Secondary (0		College (1-4 c	r 5+)	life. DO	kind of wor O NOT use	retired)			ng				
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an	be file ental l ked c ic eve	10	Edward	Wile	v				İ			e (First, Middle, Krumb i		n Surname	2)	
Maryland	should be filed within 72 h and Mental Hygiene. 7 is marked other than " traumatic event, the Mec	1	19a. Informant's Name/Rela				19b. Mailin	g Address	(Street a			I Route Numbe		or Town, S	itate, Zip C	Code)
	nd 2 s ealth a m 27 i		Mrs. Victor	a I.	Wiley(Wi	lfe)	2007	Jasm	ine	Road	Du	ndalk,	MD	2122	22	
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai		20a. Method of Disposition 1 ☐ Burial 2 ☑ Crema 4 ☐ Donation 5 ☐ Ot		Removal from Sta	te c	Place of Disposemetery, crem 11top	natory`or o	ther place			Date 28/2011		Location -	•	own, State ryland
Balt	permit. Depart Import any inj		21. Signat ke f Funeral Ser	rice Licens	gen J							Home of				
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s, P.O.	v requires that th sbeen signed by should be detad	b	Part II. Other significant co	nditions con	tributing to death	but not resi	ulting in the u	nderlying o	cause give	en in Part I	l	23e. Did t				ne cause of death?
Division of Vital Records,	The law requate has beer page 2 shou	Completed											psy ormed?	p	orior to con death?	psy findings available mpletion of cause of
al H	ician: The certificate rector, pag	Be C	25. Was case referred to med	lical				-	26. Pla	ce of Deat	th (Check	1 Yes	2 🗶 1	No 1	I ☐ Yes	2 L No
Ζ	nysicia nis certi I direct	70 E	examiner? 1 ☐ Yes 2 👿 No	Н	ospital: 1 🗌 Inpa	atient 2 🗆	ER/Outpatien	t 3 🗆 DC	Othe	r: 4 🗆 Nu	ırsing Ho	me 5 🗆 Resi	dence	6 X Othe	er (Specify)	HOSPICE
on of	Attending Physician: sr death. ector. After this certific. by the funeral director,	Certificate:	27. Manner of Death 1 🙀 Natural 5 🗆 P 2 🗀 Accident In	ending restigation	28a. Date of ir (Month, L		28b, Time of injury	M 28	Bc. Injury work? 1 🔲 \			28d. Describe l	now inju	iry occurre	ed	
Divisi	ial or Atters after de al Directo			ould not be termined	28e. Place of I building,	njury - At hor etc. (Specify)	me, farm, stre)	et, factory	, office			28f. Location (S City or Tov			er or Rural	Route Number,
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	4.41		30. Name and address of pe	·					DIN	фтыс	MITIM	. M. O.	1000	- l	t	
	Sta Registra		JACKIE JONE 31. Daugustus 12 15 20	S, CRN		trar's Signati	NEY VAI ure arks	ا ا تاماد	<u>κη•</u>	1 TWO	MLUM	I, MD 2	1093	•		
DIV	41.47.0	2044		4										~		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

11-07854 Christopher M. Wood Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar Certificate of Death Reg. No. 2011	3394
Physician Medical Examine		Time of Death 0852 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Freeland Road at I-83 North Ramp 4c. County of Death Freeland Baltimore County	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthpla	ice (State or
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any (d. Inside City Limits
te Maryland or 28a-f show any fied at once.	PA York Felton	Yes 2 No
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5-0036 led within 72 hour tygiene. other than "natt the Medical Exa	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired) Management Home Remodel	ing
ID 21215-0036 and Montal Hygiene. This marked other than "natural", and event, the Medical Examiner. To Be Completed by F	17. Father's Name (First, Middle, Last) Dwight Wood 18.Mother's Name (First, Middle, Maiden Surname) Suzanne Heffron	
MD 21 d 2 should life and Mei m 27 is man aumatic cv	19a_Informant's Name/Relationship (Type, Print) Jeffrey Wood Brother 2200 Elliotschance Court, White Hall, M	Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Chesape and the Chesape	
Balti permit. Departi Import Injury	21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21203	
Physician Wedical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	oproximate Interval etween Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhythmia Due to (or as a consequence of):	
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760, cate be execuphysician and he burial - tra	IF FEMALE: AMENDED 23a-b,pt.II,27,per me,g920 10-27-11 sm 23d. Date of delivery	
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Division of Vital Records, spital or Attending Physician: The law requirements after death. neral Director: After this certificate has been similed in by the funeral director, page 2 should be Certification: To Be Completed	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Roor or Town, State)	oute Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical E.	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.	se(s)
F \$ F 8	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, D	ay, Year)
nard	30. Name and address of person who completed cause of death (Item 23a)	
orper	Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registrar		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 25 State of Maryland Department of Health and Mental Hygiene Registrar Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death RICHARD Month **Physician** 10:25 AM 30 2011 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7 Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F 10, Maryland Oct 219-28-7435 77 Director Usual Residence of Decedent death with the Maryland or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Director MD 10e. Street and Number 10f, Zip-Code 10g. Citizen of What Country? 23a or Examiner must be 124 W. Franklin Street 21201 USA Funeral Items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. and 2 should be filed within 72 hours after ealth and Mental Hygiene. 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 ٥ 1 ☐ Yes 2 🛛 No Specify. ò Specify: White 3 Nidowed 4 Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than 8 0 journalism writer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, Be Clarence Albert Wingate Helen Margaret Mobley ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willow Wingate - daughter Health tem 27 permit. Pages 1 and Department of Healt Important: If item 2 any injury or other 8 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Scripe 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or co dition resulting in death) BRAINSTEH **Physician** Medical / to (or as a consequence of): Examiner HETTORRHUGE IMPRACRAMIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician and d for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death ed by the atten-3 - Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No Yes P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 \$ Division of Vital Records, page 2 should be The law requires 2 No 3 Probably 4 Nonknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 certificate has 21 2 🗌 No 1 Tes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 1 X Yes 1 Inpatient 2 ER/Outpatient 3 🗆 DOA ၉ 6 Other (Specify) this 27. Mann - of Death 1 atural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After t 5 Pending investigation Injury 1 Yes 2 No 2 Accident the Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) Tpletely and manner stated 29b. Signature and title qf 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who co noleted cause of death (Item 23a) MANUET BUTRAGE 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) 32. Registrar's Sign State OCT 2 1 2011

DHMH 17 Rev 1/2001 11595

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ October WITHTE TAYWOOD Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospita HOPKINS JOHNS 1+imore If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months 218-44-6726 Hours **Director** 1 X M 2 🗆 F 62 Yrs. 11-26-1948 MDshow and 2 should be filed within 72 hours after death with the Manyland Health and Mental Hygiene. tem 27 is marked other than "natural". or items 23a or 28a.4 ehm 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified MD BALTIMORE 1X Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 3508 21213 Dudley AVENUE USA rral", or items 2 Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates 3 🗌 Widowed 4 🗌 Divorced Specify: BLACK permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) CSX RAILROAD Elementary/Secondary (0-12) College (1-4 or 5+) ONDUCTOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ٩ HAYWOOD T. WHITE, II TUCKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA L. WHITE (WIFE) BALTIMORE, MD. 21213 3508 AVE . Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State **≱**Burial 2 ☐ Cremation 3 ☐ Removal from State 10/15/11 BALTIMORE, MD ESTERN STAR 4 ☐ Donation 5 ☐ Other Specify) Name and Address of Facility GREENE FUNERALSON NAUGHN nco i BALTO, MO. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Failure Mesciradory disease or condition Medical resulting in death) or as a consequence of): **Examiner** Intracerebral remarkas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Justo for as a consequence on attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed APPROVED BY MEDICAL EXAM resulting in death) Last Due to (or as a consequence of): CERTIFICATION Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown 2 No Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita Other: 은 1 X Yes 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending (Month, Day, Year) eral Director: A filled in by the f 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the I within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature apartitle of certific 29d. Date signed (Month, Day, Year) ME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Himore, ma 21287

Registrar DHMH 17 Rev 06-2011

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

Walte

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0600 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c, County of Death Tunder 1 Year | If under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Dec. 13 Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2**X**□ F **Director** 213-28-1726 80 Yrs 1930 Maryland Usual Residence of Decedent or 28a-f shov notified at shov 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Harford County Jarrettsville 1 🗌 Yes 2 🔀 No 10e. Street and Number ō 10f. Zip Code er than "natural", or items 23a or the Medical Examiner must be 10g. Citizen of What Country? Funeral 3611 Woodholme Drive 21084 United States 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates. ò 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Completed 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker other Be Maryland 17. Father's Name (First, Middle, Last) should be file and Mental F 18. Mother's Name (First, Middle, Maiden Surname) Dietrich Maas Emma LeFevre injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Terry Cellini (Daughter) 3611 Woodholme Drive, Jarrettsville, MD 21084 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial ※☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel 10/26/2011 Forest Hill, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Eacily hapel & Cremation Services-BelAir 8. Newbort Drive, Forerst Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a cor sequence of Exami that initiated events resulting in death) Last Due to (of as a consequence of): physician a the burial-Physician/Medical 68760 attending p for use as t IF FEMALE: ate has been signed by the attendin page 2 should be detached for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant Box (23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Vear 1 Yes 2 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 X 1 Yes 2 No Hospital or Attending Physician: Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes ္ဝ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Division of 27. Manner of Death 1 X Natural 28a. Date of injury 28c. Injury at work?
1 \sum Yes Certificate: 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pendina Accident Investigation M 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 Upper la Chesaneake 31. Date filed (Month, Day, Year, 32. Registrar's State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dickens W. Warfield 21, October 2011 11:45 P.M /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cockeysville Broadmead Retirement Community 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) August 27, 1925 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 🛛 F Detroit, Michigan 186-20-2374 86 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Machical Experience must be notified at Cockeysville Maryland Baltimore 1 Tyes 2 KING Directo 10e. Street and Number 10f. Zip Code 18 filited WStates 21030 13801 York Road Apt. V3 of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 21215-0036 white If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit, Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other trainment Psychology Educator 12 Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Dickens Waddell Beatrice DeWitt ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 13801 York Road Apt. V3 Cockeysville, Maryland 19a. Informant's Name/Relationship (Type. Print) H. Branch Warfield/ spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State October Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Chapel- Bel Air 21. Signature of Fungral Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. sician and burial-trans Due to (or as a consequence of) 68760. Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 mon Day Year 5 Other (specify) Ö be detached ď. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 2 1 No Division of Vital 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | N6 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-D Natural
2 Accident 5 Pending investigation 1 TYes 2 No after death Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the leading within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ WILLIAM JOSEPH WINGATE, SR. 362 2011 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE INARHINGTON MEDICAL ANNE 8. Date of Birth (Month, Day, Oct 31, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days 1 XM 2 - F Hours Country) Pennsylvania 215-18-9145 87 Director Usual Residence of Decedent with the Maryland items 23a or 28a-f sho her must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Millersville Maryland Anne Arundel 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21108 TISA 8049 Veterans Highway, Rol-Park Village 12. Was Decedent Ever in U.S. Armed Forces?

1 🔀 Yes 2 🗌 No If Yes, Give Year or Dates. WW 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or iten Black, White, etc. þ 1 Never Married 2 Married and 21215-0036 filed within 72 hours after 1 ☐ Yes 2 No Specify: Completed 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Maryland Club Security Dooman Be J. e., Marylar.

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Department of Health and Merrimportant: If item 27 ion once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Clarence Miller Wingate Gertrude Marie Durst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Martin Road, Glen Burnie, Maryland Mrs. Elizabeth M. Asbury (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State 10/24/2011 Baltimore, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kevin E Ecker McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicann/ rulmonar. Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ue to (or as a consequence of): and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician sthe burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available 24a. Was an prior to completion of cause of death? has Hospital or Attending Physician: The 24 hours after death.
 Funeral Director: After this certificate h 1 Yes 2 No 1 ☐ Yes 2 ☑ No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) . Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending iniury Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 45149 mi 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) Hocakel MABA 31. Date filed (Month, Day 32. Registr 's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 33955 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2011 Jane Arlene Whitaker 1:20 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death House of Jubilee Assisted Living Fallston Harford Social Security Number Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth 1 □ M 2 🔀 F Months Hours Min onth, Day, Y 84 Director 1927 West Virginia 232-34-6988 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2919 Grafton Lane 21028 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ۵ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. em 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 U.S. Government Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Austin Dayton Dahmer Lillian Grace Grimes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Duvall / Daughter 2100 Jacobs Well Ct., Bel Air, Maryland 21015 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn 10-25-11 Bel Air, Maryland 21. Signature of Fune al Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. nu lh 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or comp. shock, or heart failure. List only of note that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ rmer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? þ Records, The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🗆 Nursing Home 5 🗀 Residence 6 🔀 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA Assisted 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Living or Attending Natural 2 Accident iniury 5 Pending work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Aff
d in by the ful Investigation 3 Suicide
4 Homicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifie 10-71-7011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lemmers Runko, Baltimuse, MD 212 617 State Registrar

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P.O.

Division of Vital

and I-transit ires that the death been has certificate Hospital or Attending Physician; this

ds, P.O. Box 68760,

Division of Vital Recor

buriatphysician the burial attending p signed by the a d be detached f funeral director, To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

any i Certification: ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number D-38754 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier W-D-EASTERN BLVD, M.D. 2122

709.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) = ASEBM

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31. Date filed (Month, Day, Year)

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ October 8 2011 2011 7:45P. Anna Lena Altobelli Medical 4a. Facility Name (if not institution, give street and number)
Sanctuary at Holy Cross 4b. City, Town, or Location of Death Burtonsville 4c. County of Death
Montgomery **Examiner** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 🗆 M 2 💢 F Pennsylvania Jane 14, 1927 135-20-8228 84 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits at Oa. State 10b. County loc. City, Town or Location Beltsville the Maryland Director Maryland Prince George's notified 1 ☐ Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Number must be 1 Funeral 11116 Emack Road 20705 United States 23a items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Examiner Armed Forces? Black, White, etc. 5 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify: White If Yes, Give Year or Dates "natural" Completed 3 X Widowed 4 □ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Office Manager Insurance of Health and Mental Hygi item 27 is marked other other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Caroline Castrati Anthony Napoleon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 11433 Rosedale Lane Beltsville, Maryland 20705 rtment of Health a Mark J. Altobelli -son 20a. Method of Disposition
1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Gate of Heaven Cem. njury or 10/12/2011 SilverSpring, Maryland 4 Donation 5 Other (Specify) once. 21. Signature of Funeral Service License Bornald Addres Borg Wardt Funeral Home, PA Donald 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any leadin, to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Pregnant at time of death
Unknown 5 Other (specify) Month Day Year n signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate 2 No 1 Yes 1 Yes 2 No nin 24 hours after death.

the Funeral Director: After this certifica repleted filled in by the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director is the funeral director. To the Hospital or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours Medical 🖵 🗲 🕶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State

Registrar

29b. Signature and title of certifier

Sm 31. Date filed (Month, Day, Year, 32. Registrar's S 1 1 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Month 09/29/2011^{ear} 7:50 PM Fidelis Anazodo 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Clinton Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Days Hours Country) Nigeria 1272471937 215-89-8855 73 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MD Prince Georges Brandywine 10e, Street and Numbe 10g. Citizen of What Country? 50773 Nigeria 9609 Dyson Rd. 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🗷 No If Yes, Give African 1 Yes 2 No Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Rusiness Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Gas & Oil Company Company Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oramadike Anazodo Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 9609 Dyson Rd-, Brandywine, Md 20613 Chioma Obidegwu / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 10/18/2011 Anambra State, Nigeria lmuDim¬ Nnewi Village 21. Signat (re f Funeral Service Chense 22. Name and Address of Facility Strickland Funeral Services L500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Retween Immediate Cause (Final disease or condition resulting in death) CERSONO VASCULAR ACCIDENT Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?

Ph_sician/ Medical Examiner

Physician/

Medical

Director

Funeral

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permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu

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Baltimore, Maryland 21215-0036

pe ms 23a must be

with the Maryland

Examine burial-transif and ing physician as the burial Physician/Medical attending nse ō the be detached signed by þ Completed certificate has page 2 Be ည 24 hours after death.

Funeral Director: After this leted filled in by the funeral di Certificate:

death certificate be Box 68760

Hospital or Attending Physician: The law requires that the

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Records,

Division of Vital

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work?
1 Yes 2 No 5 Pending Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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State Registrar

Medical

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eath (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Norman E. Albertson October 10, 2011 9:55 A. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12110 Faith Lane Prince Georges Rowie Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 178-14-3862 1 **X** M 2 □ F Days May 6, 1923 Director 88 Pennsylvania Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Prince Georges Bowie 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12110 Faith Lane 20715 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give WW II Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Cook 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Albertson Roy Hilda Edwards 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anneliese M. Albertson/Wife 12110 Faith Lane, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Geo. Wash. University 10 Washington, D.C. 4 Donation 5 Other (Specify) Center 21. Signature of Funeral Service L 22. Name and Address of Facility Columbia Mortuary Services, P.A. /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 30 Days Immediate Cause (Final Physician/ disease or condition Metastatic Lung Cancer Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or linjury Examine Due to (or as a consequence of): and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ Live Birth 2 Fetal death in the past 12 months? Pregnant at time of death Month 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tX Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24a. Was an autopsy performed? Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital 2 X No ည 1 Tyes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Peter Eckberg,

D35820

14300 Gallant Fox Lane #110 Bowie, MD 20715

October 12, 2011

State of Maryland / Department of Health and Mental Hygiene For State Registrar 33960 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Priscilla Green Biondo 201 Team 4:40 PM S October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death e Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) AL 1 □ M 2 🗓 Days Hours 0 577-40-6107 April 8, 1926 **Director** 85 Usual Residence of Decedent 10b. County ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11508 Monongahela Ct. 20852 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 2 🛛 No 1 Yes If Yes, Give 21215-0036 Specify.White 1 ☐ Yes 2 K No Specify: 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Prisc nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Artist Self-Employed Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Harrison Green Martha Louise Thayer it. Page 1 and 2 shours of Health and Mr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mauro A. Biondo/Husband 11508 Monongahela Court, Rockville, MD 20852 permit. Page 1 and 2
Department of Healt
Important: If item 2
any injury or other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Oct. Date 7, 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 2011 Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease ase or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between shock, or heart failure Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the buria-tra-Due to (or as a consequence Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 menths? Live Birth 2 Live Fetal 300... Dav Year 1 ☐ Yes ≥ 1 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate Yes 2 No Yes 2 No 25. Was case referred to medical 8 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🛣 No Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 2 Accident 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending inlury 1 Yes 2 No Director; / 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Externiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Centry includes Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Signature and title of 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10301 Georgia Ave +203 Silver Spring MD 20902 Heshmat MD 31. Date filed (Month, Day, Yea State 07 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Mary				and Me	ntal Hyg	iene		- 4
			State Registrar 1. Decedent's Name (First, Middle, L.)	cotl	Cer	ertificate of Death Reg. No. 2					33961	
н	Physicia	ın/ [°]	John J. Baka	asi)					Date of Deat Month	Day	Year	3. Time of Death 12:47 P M
~	Medio Examin		4a. Facility Name (if not institution, given	ve street and number)		4b. City, Town, or	Location of		Oct 7, 2	4c. County of	of Death	
			Southern Maryland Hospital			Cli	nton			Pri		orge's
	Funeral		Social Security Number 6.	Sex 7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		Date of Birth (Month, Day, an 28, 1	Year)	9. Birthpla Countr	ace (State or Foreign y) lampshire
	Director		163 38 8162 Usual Residence of Decedent	X 65	115.			J	an 28, I	.946	New 1	ampshire
	land shov d at	ξ	10a. State 10b. County	100	c. City, Town or Loc	ation					10	d. Inside City Limits
	Mary 28a-1 otifie	Director	Maryland Prince Ge	orge's	Upper	Marlboro						1 🗆 Yes 2 😾 No
	ith the 23a or st be r	ral	10e. Street and Number 8510 James S	troot		10f. Zip Code 207	72		1	10g. Citizen of What Country? United States		
	ems arm	Funeral	11. Marital Status	12. Was Decedent Ever		Vas Decedent of Hi	spanic Origi				- Americai	
Armed Forces? 1 Never Married 2 X Married 1 Ves 2 No If Mass (ive)						Yes, specify Cuba		Puerto Rica	an, etc.)		k, White, et	
21215-0036	ours a	Completed by	3 Widowed 4 Divorced	Year or Dates.		Yes 2 No Specify:					Specify: White	
5	72 hc	mple	(Specify only highest of	grade completed)	(Give h	ent's Usual Occupa ind of work done d O NOT use retired)	fone during most of working				siness Indu	ıstry
212	withir giene ier tha		Elementary/Seconday (0-12)	College (1-4 or 5+)	Met	ro D.C. Pol	lice			Ci	ty Gov	ernment
nd	e filed ital Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)			18. Mother			faiden Surname))	
3	should be filed within 72 hours after death with the Maryland and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f sho raumatic event, <u>the Medical Examiner must be notified at</u>	_	Joseph J. Baka 19a. Informant's Name/Relationship	(Time Print)					anda Gal		7. 0.	24-1
∑	and 2 sho Health an tem 27 is other trau		Valerie L. Baka (g Address (Street a James Stre					ate, zip co	ide)
Baltimore, Maryland	of Hear of Hear fitem rothe		20a. Method of Disposition	2	0b. Place of Dispos		1	Date		20c. Location -	City or Tow	n, State
<u><u>H</u></u>	. Page 1 tment of 1 tant: If it		1 Burial 2 X Cremation 3 4 Donation 5 Dother (Spec	cify)	Lee Crematory Oct 9, 2011				Clinton, Maryland			
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Line		153 22	Name and Addres	s of Facility 1, Clin	Lee Fu	meral H D 2073 5	ame,Inc 6	633 01	d Alexandria
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate								Approximate interval Between				
~	Physician/ Medical		Immediate Cause (Final disease or condition	a. Vent	nacio	Fib	1110	anc	20			Onset and Death
	Examiner		resulting in death) Due to (or as a consequence of):									
		iner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cor	sequence of):			17 11	all I	10,1		
	cuted nd rransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	· Hypx		5100						
_	ite be executed hysician and he burial-transit	dical E	resulting in death) Last	Due to (or as a con	isequence of):							
760	cate b	ledic		d								
89	ath certifica attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pro	egnancy	Ectopic pregnance	v			23d. Date	e of deliver	y
Вох	that the death certificate be executed ned by the attending physician and s detached for use as the burial-transif	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time 9 Unknown		Other (specify)	у			Mon	nth D	ay Year
<u>Р</u>	requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions	contributing to death but no	t resulting in the ur	nderlying cause giv	en in Part I.		23e. Did tob	acco use contril	bute to the	cause of death?
ds,	requires been sign	ted t							1 🗆 Ye	s 2 No :	3 🗌 Proba	ably 4 🗆 Unknown
Vital Records,	law red nas ber e 2 sho	Completed							24a. Was ar autops	y pr	rior to com	y findings available pletion of cause of
Re	hysician: The law r his certificate has b I director, page 2 sl		of Manager						perform		eath?	□No
/ita	Physician: The this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ 100	Hospital:	2 R/Outpatient	_ Othe	ace of Death			nce 6 🗆 Other	(Oi6-)	
ot	ng Phy ter this neral c		27. Manner of Death	28a. Date of injury (Month, Day, Yea	28b. Time of	28c. Injury	at			w injury occurred		
<u>0</u>	tendir leath. tor: Af the fu	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not	on he		M 1 🗆 '	Yes 2 N					
Division of	al or At s after o		4 Homicide determined			et, factory, office		28f.	Location (Str City or Town,	eet and Number State)	r or Rural R	loute Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certifical completed filled in by the funeral director, to	Medical	(Check 2 Medical Exam	ysician: To the best of my k niner: On the basis of examir rse Practioner: To the best	nation and/or investi	gation, in my opinio	n, death occi	curred at the	time, date and	d place, and due	to the caus	e(s) and manner stated.
	To th within To th сотр	2	29b. Signature and title of certifier	O Traditioner. To the best	or my knowledge, di	29c. License	number	_		9d. Date signed		
	DC			216		DG	2057	7		10/-	1/2	011
20	1+0		30. Name and address of person who	completed cause of death		int) II ROA	D. CO	LINZ	ON I	no -	2073	3-2
	Stat Registra	e ir	31. Date filed (Month Dev. Year)	2011 32. Registrar's Si	gnature	arke						
					7.8							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Marylan	d / Departme	ent of Health and	Mental Hygien	е	
			State Registrar		Certifica	ite of Death	Reg. N	10. 201	1 33962
	Physicia		1. Decedent's Name (First, Middle, Las	h m P	rand	05	2. Date of Death Month	Day Year	3. Time of Death
л	Medi Examir		4a. Facility Name (if not institution, give	street and number)	4b. Ci	y, Town, or Location of Deat	th 2	c. County of Deat	h
			1612 HUR	son Rd	10	ambrid	oce	Dorc	nester
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. In	ast birthday) If Und Yrs. Month	der 1 Year If Under 24 Hrs s Days Hours Min		9. Birt	thplace (State or Foreign
	Director		Usual Residence of Decedent		113.		Jegn 3, P	12/11	10
	and show	Ď	10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
1	the Maryland or 28a-f sho e notified at	Director	MD Doru	waster	Car	bridge			1 🗆 Yes 2 🗖 No
3	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ralD	10e. Street and Number.	a D.O	10f. 2	Zip Code	10g. (Citizen of What Co	puntry?
Ze	death wi	Funeral	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. Was Dec	edent of Hispanic Origin? (S	Specify Yes or No-	14. Race - Ame	rican Indian
9	or ite	by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	If Yes, sp	ecify Cuban, Mexican, Puer	to Rican, etc.)	Black, White	
5-0036	hours after natural", or lical Exami		3 ₩idowed 4 Divorced	If Yes, Give Year or Dates.	1 L Yes	2 4No Specify:		Specify: L	Phite
5-(2 hou "nat edica	blet	15. Decedent's Ed (Specify only highest gra		16a. Decedent's Us (Give kind of v	ork done during most of wo	rking 16b.	Kind of Business	Industry
2121	within 72 giene. er than "i , the Med	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO NOT L	rse retired)	h	ealt	reave.
	filed will all Hygid of other svent, t	Be	17. Father's Name (First, Middle, Last)		<u> </u>	18 Mother's Na	me (First, Middle, Malde	Surname)	ica e
Maryland	should be filed within 72 hours aften and Mental Hygiene. 7 is marked other than "natural", raumatic event, the Medical Exan	은	Williams S	tede wh	eatler	y Eva	Mays	seler	ord
fan,	shoul and I is ma		19a. Informant's Name/Belationship (Ty	pe, Print)	19b. Mailing Addre	ss (Street and Number or Ri	ural Route Number City	or Town, State, Zin	Code) 21013
	and 2 Health tem 27		Mark J. D	aver-son	11012	Huason	ra, ca	mona	GE, MID
Baltimore,	Page 1 ament of the ant: If its ury or of		20a. Method of Disposition 1 Description Description Burial 2 Description 3 Descripti	Removal from State	Place of Disposition (Nemetery, crematory of	other place)	Date 20c.	Location - City or	Town, State
ij	permit. Page Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Juneral Service Licens		XUI VILLE	and Address of Facility	15 40/1 C	pinya	Ge MI
Ba	permit. Departr Imports any inju		F Thered-	Branca	40 308	High St.	Cambrage		1613
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	plications that caused the death	h. Do not enter the mo	ode of dying, such as cardia	c or respiratory arrest		Approximate Interval Between
~	Physician/	L	Immediate Cause (Final disease or condition	MV	ploduso	19519			Onset and Death
100	Medical Examiner		resulting in death)	Due to (or as a conseq.	uence of):				
		er	Sequentially list conditions,	b. Due to (or as a consequ	ience of):				
	ted 1 Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	24010 (0. 404 00.1009)	201100 01/1				
	execu an and ial-tra	Ex	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):				
09	ate be executed chysician and the burial-transit	edical		d					
687	rtifical ing ph e as th		IF FEMALE:						
Box 6	attending p	ian/	in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3 🗌 Ectopi			23d, Date of de Month	livery Day Year
Ğ.	that the desired by the a	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	Jeath 5 Li Other	specify)		morna.	
P.0.	that the	by PI	Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlyin	g cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
JS,	w requires that s been signed k should be det	edb					1 🗆 Yes	2 √ 10 3 □ P	robably 4 🗆 Unknown
of Vital Records,	aw rec as bee 2 sho	Completed					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
Rec	ician: The law certificate has rector, page 2	Som					performed?	death?	
tal	ysician: is certific director,	æ	25. Was case referred to medical examiner?	Hospital:		26. Place of Death (Che	eck only one)		
fΝ	Physi this c	은	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Inpatient 2 Inpa	ER/Outpatient 3 28b. Time of		Home 5 Residence		sify)
0 L	ding th. After funer	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ary occurred	
Division	Atten	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho	me, farm, street, facto	<u> </u>	28f. Location (Street a		ral Route Number,
Ď	tal or its afte al Dire		,	building, etc. (Specify) 		City or Town, Sta	te)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transity.	Medical	(Check 2 Medical Examin	ician: To the best of my knowl ner: On the basis of examination	and/or investigation, i	n my opinion, death occurred	at the time, date and place	ce, and due to the	cause(s) and manner stated.
	To the I within 2 To the I complete	ž	only one) 3 ☐ Certifying Nurs 29b. Signature and title of certifier	e Practioner: To the best of my		curred at the time, date and p 9c. License number		e(s) and manner as Pate signed (Month	
	- 3 - h		Garage			1451762	11	15/11	.,,/
			30, Name and address of person who ca	ompleted cause of death (Item	23a) (Type, Print)	1121197	1/0	1///	
_			Eugene Newmie	C DO. 331	Porchest	E Ave Svit	el Cam	bo deci	MP 31613
	Sta Registra		31. Date filed (Month, Day, Year)	32 Registrar's Signat	A Som	,		/	

DHMH 17 Rev 7/2009

1 - For State Registrar Baltimore, Maryland 21215-0036 🔾 🖟

Physician	/	Decedent's Name (First, Middle, La ANN DEMEYER BLAK	· ·					2. Date of Death
Medica Examine		4a. Facility Name (if not institution, give	e street and number)				r Location of Death	
with the Maryland 23a or 28a-f show ust be notified at	tor	5557 MT • HOLLY R 5. Social Security Number 6. S 215-16-8095 1 Usual Residence of Decedent 10a. State 10b. County 10c. Street and Number 5557 MT • HOLLY RO	Sex 7. Ag		Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth FEB. 16
ed within 72 hours after of Hygiene. other than "natural", or i ent, the Medical Examin	Be Completed by	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced 15. Decedent's E(Specify only highest grades) Elementary/Seconday (0-12) 11 17. Father's Name (First, Middle, Last)		No	16a. Deced (Give k	Yes, specify Cuba Yes 2 No ent's Usual Occup	eation during most of won	Rican, etc.)
and 2 should be fill Health and Mental tem 27 is marked of the traumatic every	으	JACOB DEMEYER 19a. Informant's Name/Relationship (1) FREDERICK P. COLL					and Number or Rui	TIMMERMAI ral Route Number, C
permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		ce	MEW M	sition (Name of eatory or other place) ARKET CEM. Name and Addre ELLER FUI 06 MAIN		Date 2 /2011 H
Physician/ Medical Examiner	Ter	23a. Par 1. Enter the disease, or come shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	conseque	nce of):	r the mode of dyin	g, such as cardiac	or respiratory arres
ath certificate be executed attending physician and for use as the burial-transit	cian/Medical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	C. Due to (or as a	a conseque	ence of):			
at the death certification of the attending etached for use a business.	by Physician/IN	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes → SNo 9 ☐ Unknown Part II. Other significant conditions of	4 ☐ Pregnant a 9 ☐ Unknown	2 ☐ Fetal t time of de	death 3 Leath 5 L	Ectopic pregnand Other (specify)		23e. Did toba
he law requires that the de te has been signed by the age 2 should be detached	Completed by					loonying databagi		1 Yes
ng Physician: Iter this certificaneral director,	lo pe	25. Was case referred to medical examiner? 1	oe 280 Place of Init	y (, Year) 2	R/Outpatien 28b. Time of injury ne, farm, stre	DOA Oth 28c. Injur work M 1	4 ∐ Nursing H y at √?	1 L Yes 20 k only one) ome 5 Sesiden 28d. Describe how 28f. Location (Stre City or Town,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the to	Medical	(Check 2 Medical Exam	rsician: To the best of iner: On the basis of each oner: To the	my knowle	and/or investi	gation, in my opinio	on, death occurred a e time, date and pla	nd due to the cause at the time, date and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4c. County of Death DORCHESTER g. Birthplace (State or Foreign NEW YORK ^(ear)1920 10d. Inside City Limits 1 ☐ Yes 2 🕅 No Og. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: WHITE 16b. Kind of Business Industry CLOTHING MANUFACTURING aiden Surname) City or Town, State, Zip Code) LFORD MD 21677 20c. Location - City or Town, State EAST NEW MARKET, MD BOX 207 MARKET MD 21631 Approximate Interval Between Onset and Death 23d. Date of delivery Day Year acco use contribute to the cause of death? 2 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? nce 6 Other (Specify v injury occurred et and Number or Rural Route Number, e(s) and manner as stated. place, and due to the cause(s) and manner stated ause(s) and manner as stated 29c. License number
D 47924 29d. Date signed (Month, Day, Year) 10.5.2011 BYRN ST CAMBRIDGE MD 21613

4 201 Year

9:08 A M

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month,

30. Name and address of person who completed cause

Division of Vital Records, P.O. Box 68760

completed cause of death (Item 23a) (Type, Print)

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:20 am Jean H. Brown October Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery Social Security Number If Unde If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours 217-14-7033 **Director** 1 🗆 M 2 🗶 F Yrs 01/15/1921 90 New York Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County death with the Maryland 10c. City, Town or Location Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o must be i Funeral 20904 1001 Hollywood Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status an "natural", or iter Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene.
of Health and Mental Hygiene.
If item 27 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fannie Bloom Louis Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia 20191 Irving B. Brown - Son 2303 Toddsbury Place, Reston, Department of Health Important: If item 2; any injury or other to once. 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State King David Mem. Gardns: 10/09/2011 | Falls Church, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signatur 1/11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Pneumonia Cause (Disease or injury and that initiated events Due to (or as a consequence of): resulting in death) Last buria attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ ģ in the past 12 months?
1 Yes 2 No Year Month Pregnant at time of death 9 Unknown Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Altered Mental Status 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Acute Renal Failure has autonsy page performed? Yes 2 No Gastrointestinal Bleed (Non 1 Yes 2 No 25. Was case referred to medical 26. Pl e of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 X Yes 2 ☐ No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of Certificate: 28d, Describe how injury occurred (Month, Day, Year) injury 1 X Natural 5 Pending s after death. 1 Yes 2 No 2 Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be within 24 hours after dex To the Funeral Director 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) City or Town, State) Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certife 29d. Date signed (Month, Day, Year) βO D68096 October 05. 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Satyam Ashvinkumar Shah, M.D., 1500 Forest Glen Road, Silver Spring, MD 20910

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar
DHMH 17 Rev 7/2009

State

Joselito Magday, M.D. 11701 Roby Avenue Beltsville, Maryland 20705

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

1 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death evindale Himore 6. Sex 1 **X** M 2 \square F . Age (In yrs. last birthday) If Under Year If Under 24 Hrs. **Funeral** 8 Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. 0571971943 68 Director 220-40-4444 WASHINGTON, DC Usual Residence of Decedent show 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f sl Examiner must be notified MD QUEEN ANNE'S 1 Yes 2 X No CHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1321 QUEEN ANNE DRIVE 21619 UNITED STATES 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No 1962-Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: WHITE Completed 3 Widowed 4 Divorced 1965 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) LOGISTICS ENGINEER 12 FEDERAL GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ LEWIS BOWMAN other traumatic FRANCES MASSIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 MARGUERITE BOWMAN / WIFE QUEEN ANNE DRIVE, CHESTER, MD 21619 Department of Healt Important: If item 2 any injury or other i 1321 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date CHESAPEAKE CREMATION
CENTER 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/12/2011 STEVENSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN
106 SHAMROCK ROAD, HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a cons quence of) attending physician and for use as the burial-trans Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Birth 2 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 5 Other (specify) g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy After this certificate 2 No Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 140 ျှ 1 Yes 1 Impatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner eath 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Z atural injury in 24 hours after deaun.
the Funeral Director: Aff 5 Pending work 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signa 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print)

State

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

West Beliedere Avenue

Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

		Pieas	State of Ma				-	•	e.
		For State	State of Ivia	-	Department of I Certificate of I		•	201	1 2206
		Registrar 1. Decedent's Name (First, Middle,	Last)		Certificate of I	Deatri	2. Date of Dea	Reg. No.	3390
Physicia Medic	al	Asia	Bernst	ein			Month Octobe	Day Yea	3. Time of Death 9:45 AM
Examin	er	4a. Facility Name (if not institution, sacred Heart 1				or Location of Deat ttsville	h	4c. County of Di	eath George's
Funeral Director		5. Social Security Number 422–96–3677	6. Sex 1 □ M 2 🖾 F	(In yrs. last birth	Months Days	If Under 24 Hrs Hours Min.		v. Year)	Birthplace (State or Foreign Country) ithuania
land Fshow dat	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
ne Mary or 28a-1 notifie	Funeral Director	Maryland Prince	e George's	Hyat	tsville 10f. Zip Code			10g. Citizen of What	1 ☒ Yes 2 ☐ No
h with tl ns 23a o nust be		5805 Queens Cl	hapel Road			20782		USA	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Marrie 3 Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates.		13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ☒ No	an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Al Black, Wi Specify: V	
ithin 72 hou ene. r than "nat the Medica	Completed	15. Decedent (Specify only highes Elementary/Seconday (0-12)	's Education t grade completed) College (1-4 or 5+	,	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired) omemaker	during most of wor	rking	16b. Kind of Busine Own Home	ss Industry
ld be filed w Mental Hyg arked othe atic event,	To Be	17. Father's Name (First, Middle, La A. Weinerman	ist)	I		18. Mother's Na	me (First, Middle,	Maiden Surname)	(Unav.)
nd 2 shou saith and n 27 is m er traum:		19a. Informant's Name/Relationship Henry Bernster			Mailing Address (Street .O. Box 504				Zip Code)
Page 1 ar nent of He int: If iter		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		cemeter	Disposition (Name of y, crematory or other place olitan Cremato		Date 11/2011	20c. Location - City Alexandria	or Town, State
permit. Departinimporta any inju		21. Signature of Funeral Service Lic	CAn Royan		22. Name and Addre	•		4739 Bal	timore Avenue 11e, MD 20781
Physician/		23a. Part 1. Enter the di-ease, or c shock, or heart failure. List on Immediate Cause (Final disease or condition	omplications that caused to ly one cause on each line.						Approximate Interval Between Onset and Death 15 Months
Medical Examiner		resulting in death)	Due to (or as a c	consequence o	ŋ:				15 Months
ed sit	Examiner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as a c						15 Months
be e	g	that initiated events 'resulting in death) Last	c. Due to (or as a d	consequence of):				
tificate ng phy as the	Med	IF FEMALE:							
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	ру		23d. Date of Month	delivery Day Year
ires that the signed by do be detailed		Part II. Other significant condition Chronic Obstru	-		, , ,	ven in Part I.			to the cause of death?
law requ nas been e 2 shoul	Completed by						24a. Was a	sy prior t	autopsy findings available o completion of cause of
an: The tificate I or, pag		25. Was case referred to medical	1		26 PI	ace of Death (Che	1 🗌 Yes	rmed? death 2 No 1 🗆	? ∕es 2 □ No
ysicia s cert direct	70 B	examiner? 1 Yes 2 No	Hospital:	t 2 🗆 ER/Out	patient 3 DOA Other	ori		lence 6 Other (Sp	acifu)
nding Ph ath. r: After th		27. Manner of Death 1 🔀 Natural 5 🗌 Pending 2 🔲 Accident Investiga	28a. Date of injury (Month, Day,)	28b. Ti	me of 28c. Injury	y at		ow injury occurred	
al or Atte s after de al Directo ed in by th		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		- At home, farr Specify)	m, street, factory, office				Rural Route Number,
he Hospit in 24 hour he Funera pleted fill	Medical	(Check 2	Physician: To the best of ma aminer: On the basis of examiner: To the be	mination and/or	investigation. In my opinio	on, death occurred:	at the time date ar	nd place, and due to the	e cause(s) and manner stated.
o de wife de la constant de la const		29b. Signature and title of certifler	Monda	An.	29c. License	onumber 0012121	2	29d. Date signed (Moo	
A		30. Name and address of person where Geo Fleming Se				rive, Whe	eaton, M		
State Registra		31. Date filed (Month, Day, Year)	32. Registrar's			-	-		-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 23aPtI,25 per me. 9920,10/21/2011dhb

Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Numbe If Under 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8 Date of Birth **Funeral** 1 X M 2 - F (Month, Day, Year) Hours Director 841 16 New York Usual Residence of Decedent Show 10a. State 10b. County be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 🙀 Yes 2 🗌 No MI berdeen Har 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a item 27 is marked other than "natural", or items 23 other traumatic event, the Medical Examiner must 21001 Mulan JSA within 72 hours after death 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Ď 1 🗷 Never Married 2 🗆 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 □ No Specify: Completed 3 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 11+h grade 1 den + Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. Baez Jeannette Perez - Vis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeannette Aberdeen, Maryland 21001 wan Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) St. Raymond Cemetery 4 Donation 5 Dother (Specify) 8 12011 21. Signatur / F right Service of 22 Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused shock, by heart failure. List only one cause on each line er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Monary disease or inditional resulting in death) Medical Due to (or as a consequence f): Examiner NUT Midline Carcinoma Sequentially list conditions Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 CERTIFICATION A IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Day Yes 2 No signed by the a d be detached t 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 12 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 1 NO Hospital Other: မ 1 npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 24 hours after death Funeral Director. the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

EGBUTA HINYERE 31. Date filed (Month, Day, Year) 21 20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29c. License number

RESOU

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33969 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Earl clinton Gox 04:36 A M 2011 /Medical 10 07 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Harford Memoral nospital Harfor Harrede Grace 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Date of Birth (Month, Day, Year) 1 X M 2 □ F Months Days Hours Min 217-30-3747 Director 7/29/1935 PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🛣 No MD Ceci1 Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 671 Lombard Road 21911 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☑
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 🕱 No Specify 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Heavy Equip Operator Hagly Museum 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 2 George Cox Mary Curly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet B. Cox - wife 671 Lombard Road, Rising Sun, MD 21911 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rosebank Cemetery 10/12/2011 Rising Sun, MD 21. Signature Funeral Service Licenses 22. Name and Address of Facility R.T. Foard Funeral Home, PA mi H 111 S. Queen Street, Rising Sun, MD 21911 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ayythnia

Due to (or as a consequence of): /Medical Examiner 48-72 hrs MI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): chronic kidney disease Physician/Medical as yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year □Yes 2□No 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 No 1 □ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 100 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Beath 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0707-51 10/07/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper chesapeake Dr., Bel Air 21014

12. Registrar's Signature 10 Aastha settu.

State Registrar 31. Date filed (Month, Day, Year)

Box 68760,

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Records,

Division of Vital

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year CLARETTA С. CARROLL OCT 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 - F Director 577-58-6221 84 WASH MARCH Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at Director 10c, City, Town or Location 10d, Inside City Limits PRINCE GEORGES MD. TEMPLE HILLS 10e. Street and Numbe ō 10f. Zip Code 10a, Citizen of What Country? Funeral 23a 2008 JAMESON ST. 20748 U.S.A. Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò ō 1 Never Married 2 X Married 1 ☐ Yes 2 X No 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: BLACK Completed er than "natur , the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) TEACHER MUSIC is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ SAMUEL W. MANILLA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. MARTIN E. CARROLL SR./HUSBAND 2008 TEMPLE HILLS, MD. JAMESON ST., 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 T Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY OCT.7, 2011 RIVERDALE 21. Signature of Funeral Service Licensee AL HOME AVE E & CREMATORIUM, P. A. RIVERDALE, MD. 20737 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of e attending physician and for use as the burial trapsit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ Month Pregnant at time of death Day signed by the a d be detached for 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes 2 월 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No After this certificate 2 🗌 No 1 🗌 Yes npleted filled in by the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital 2 No Other: ည 1 Yes 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Natural 5 Pending (Month, Day, Year) 1 🗌 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Confifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying furse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 only one Signatur 29c. License number son who completed cause of death (Item 23a) (Type, Print) 30. Name and address

:15 D

D.C.

1 √ Yes 2 □ No

MD

Approximate Interval Between

Onset and Death

Year

State

31. Date filed (Month, Day,

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 6 ay 2011 Year 9:15 Florence Kay Chaney Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min 7. Age (In yrs. last birthday) 8, Date of Birth 9. Birthplace (State or Foreign Hours July 24. Washington, DC 76 577-44-9391 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Marvland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1025 Hvland Lane 20657 United States 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 M No Black, White, etc. ð 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 B No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Non Profit Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Richard Thomas Phillips Florence Ida Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard C. Chaney, Sr./ Husband 1025 Hyland Lane, Lusby, Maryland 20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🔛 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory: 10/07/2011 | Alexandria, Virginia . Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home. P.A. P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of) disease or condition resulting in death) 2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last IF FEMALE: es, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Anemia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? autopsy 1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one)

Physician/ Medical Examiner signed by the attending physician and abe detached for use as the burial-transit

cate has been signal

After this certificate

within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, the Hospital or Attending Physician:

death certificate be P.O. Box 68760

Division of Vital Records,

Funeral

Director

show

or 28a-f sl notified

ms 23a or must be r

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items

"natural", or iten ledical Examiner r

f Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me

Department of h
Important: If ite
any injury or ott

Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical Completed Be Certificate:

25. Was case referred to medical examiner? 2 🗆 Ko 27. Manner of Death

5 Pending

determined

Shah/1388

1 Matural

2 Acciden Accident

4 Homicide

28a. Date of injury (Month, Day, Year) Investigation 6 Could not be

Other: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of injury

28c. Injury at work? 1 ☐ Yes 2 ☐ No

D0072608

4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

NIMIT SHAH, MD

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

MD100 Hospital Road, Prince Frederick, MD 20678 Nimit A. Shah,

State Registrar

31. Date filed (Month, Day, Year) 32. Registra's Signature

JRW)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 23a State of Maryland / Department of Health and Mental Hygiene State Registrar Amend#6perfuneralhome10/19/11ccdohtsertificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Selma F. Carl October 6 5:19 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bradford Oaks Center Clinton Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, D 1 M 2 X F Months Days Hours Min Day, Director 21460 1517 84 1927 Brazil Usual Residence of Decedent or 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County Director 10c. City, Town or Location 10d. Inside City Limits be notified Maryland Prince George's Temple Hills 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ms 23a must be 2706 Afton Street 20748 United States "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 Yes 2 X No If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Completed al Hygiene. I other than "natura vent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) f Health and Mental Hygiene item 27 is marked other th other traumatic event, the Homemaker Own Home 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Daniel Frederico Paulina Rott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis W. Carl (Husband) other 2706 Afton Street, Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/11/2011 Clinton, MD Resurrection Cemetery permit. 21. Signatu 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Clinton, MD 20735 Ferry Road. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Therescleration Immediate Cause (Final Ph_sici_n Cardis vareler Onset and Death disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Parkinsonism Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). burial-transi and resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical that the death certificate be P.O. Box 68760 as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown ō Pregnant at time of death Month Day Year Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ठ् Division of Vital Records, or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? performed' certificate 2 No Yes 2 No 25. Was case referred to medical director Be 26. Place of Death (Check only one) Hospital 2-1 No Other: 1 Yes this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work' Accident М 1 🗌 Yes 2 🗌 No Investigation 2 ☐ Accider 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) building, etc. (Specify) To the Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D65365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ms stor at HIP, Al WAShington 1170/ 11-1 M.D MicHA idaneul1

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mo

32. Régistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 201^{Ye} Hazel Leitata Cheesman October 10:12 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mallard Bay Care Center Cambridge Dorchester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** ^{Year)} 1919 Months Days Hours (Month, Day, June 15, 1 ☐ M 2 😾 Maryland 214-07-9129 92 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show or than "natural", or items 23a or 28a-f short the Medical Evantine author notified at Director Dorchester 1 ☐ Yes 2 X No Wingate 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4669 White Marsh Road 21648 USA permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23; any Injury or other traumatic event, the Medical Evantural angonge. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Baltimore, Maryland 21215-0036 1 Never Married 2 Married ģ 1 ☐ Yes 2 🕱 No Specify: white Specify: 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) seamstress garment mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ottie W. Mills Nora Greene ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janie C. Adkins daughter 110 Maple Avenue, Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Dorchester Mem. Park 10/10/11 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 14 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Clementia 18XX /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be execu burial-trai resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by hupertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? cate has I 24a. Was an autopsy performed ial or Attending Physician: The safter death.

I Director: After this certificate ed in by the funeral director, pag 2 🗆 No 1 ☐ Yes 2 ☐ ¥ lo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 T Homicide To the Hospital of within 24 hours a To the Funeral D Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

211/16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ohnson



100 Branble

State of Maryland / Department of Health and Mental Hygiene

1 - State Amend 20b per FD, 10/11/11, Certificate of Dooth

1. Decedent's Name / First 1997. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician /Medical 2011 (f) not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner (10 If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age Date of Birth (Month, Day, (In vrs last birthday **Funeral** Months Min. Year) .58 1 2 M 2 □ F Days Hours Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits ral", or items 23a or 28a-f show Examirer must be rufffed at 1 ☐Yes 2 ☐ No Directo ni 10e. Street and Number 10g. Citizen of What Country? Funeral Pages 1 and 2 should be filed within 72 hours after deament of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or items 12- Was Decedent Ever in US Armed Forces? 1 ■ 1es 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Baltimore, Maryland 21215-0036 1 Never Married 2 Married If Yes, Give Year or Dates: <u>م</u> 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced Completed item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vans 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , 97appe, MD 21673 20c. Location City or Town, State 20b. Place of Disposition (Name of EASTER NEW ATMARKE Place 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any injury or otl 1 ■ Burial 2 □ Cremation 3 □ Removal from State 10-11-2011 Elest Lew Market, MV 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Curren-Brancolou FH, PA 21. So petors of Funeral Service Licensee Approximate Interval Between Onset and Death Patt 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER PANCREATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be execute burial-tra Due to (or as a consequence of): Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 | Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. Tyes 2 TNo Unknown 9 Unknown is been signed by the should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an page 2 autopsy performe /es 2 1 □Yes Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 DNo Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6 Other (Specify) + OSPICE After this 27. Manner of Death 1 Natural 2 ☐ Accident completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation death. 1 □Yes 2 □No hours after death uneral Director; 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0066409 10-6-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8221 Teal Drive, Easton, MD 21601

, MD 2. WILLIAM GAI

31. Date filed (Month, Day, Year) OCT 11 201 . Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Martha Collier Cousins 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5703 Riverton Court Cambridge Dorchester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, October **Funeral** 1 M 2 X F Director 216-38-3934 Maryland 74 6,1936 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Dorchester 1 🗌 Yes 2 🕱 No Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 5703 Riverton Court 21613 USA permit. Page 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mulonce. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 Tes 2 X No If Yes, Give Year or Dates. 1 Tes 2 No Specify: white Specify: 3 X Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) personal assistant government agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William I. Collier Francis Donaldson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lemmert M. Cousins II son 5703 Riverton Court, Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗀 Cremation 3 🗆 Removal from State 10/7/11 Maryland Veterans Cem Hurlock, MD 4 Donation 5 Other (Specify) nure of Funeral Service icenses 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician CIPRHOSIS -IVRA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been si should l 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s performed No autopsy ours after death. eral Director: After this certificate filled in by the funeral director, page 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 24 No Hospital: 힏 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mapper of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 10 10-03-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

OCT 0 5 2011

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Registrar's Signa

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		for State Registrar	oratio or many tan		ate of Death	Reg.	0011	33976
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and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
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2 288 P. 128	Funeral Director	10e. Street and Number	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Zip Code	10g.	. Citizen of What Co	untry?
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tams	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was De	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puert	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
5-0036 72 hours after natural, or its	by	3 Widowed 4 Proivorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 🖵 Yes	2 No Specify:		Specify: R1	ack
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Mary d 2 shou th and M 7 is man	_	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailing Addre	ss (Street and Number or Ru	ral Route Number, C		ip Code)
127 E G		Joseph Ti.	Tohnson	102 H	eath Road Ci	resterte.		1.21620
of H its		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re	emoval from State	Place of Disposition (A cemetery, crematory of	lame of r other place)	alii n	c. Location - City or	~
Caltim permit. Pag Department Important: any injury c		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		the same of the sa	and Address of Facility		urrisvill	e, MD.
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Physician	F 1	Immediate Cause (Final disease or condition	Metasta	0	reast Ca			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consec		720131 - 000	veceo		- MONTHS
Examine.	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	Tuence of):				
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eath c atten	Physician/M	in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3 □Ectopic			23d. Date of deli Month	very Day Year
oy the arched	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown					
gned gedet		Part II. Other significant conditions con-	$\rho \sim 10^{-1}$		cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
w requires been signishould be	ted	End Stage	tenal D:	'sease		1 🗆 Yes	2 XNo 3 □ Pro	obably 4 Unknown
Has b	Completed by					24a. Was an autopsy	prior to c	topsy findings available completion of cause of
Physician: The law requires thet the death this certificate has been signed by the atterral director, page 2 should be detached for un		OF Management and the state of		This is		performed 1 ☐ Yes 2 🖪	1? death? No 1 ☐ Yes	2□ No
ysicia ysicia s certi	o Be	25. Was case referred to medical examiner?	ospital:	ER/Outpatient 3 ☐ I	Other	h <i>Check onl. one</i> ome 5 Residence	e 6 Other (Spec	Hospice
og Phy ter this	Ë	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how		my rouse
tending leath. for: Afte the fune	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(M	1 Yes 2 No			
or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office	28f. Location (Stree City or Town, S	t and Number or Ru State)	ral Route Number,
spitel		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	awano danth accum	d at the time, date and plans	and his to the caus	del avitado que ae	etab.et
To the Hospitel or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physimple left filled in by the funeral director, page 2 should be detached for use as the	edical	(Check only 2 Medical Examin one)	er: On the basis of examina and manner stated.	ation and/or investigation	on, in my opinion, death occur	red at the time, date	and place, and due	to the cause(s)
	Ž	29b. Signature and title of certifier	50 00 1	2	9c. License number	29d.	Date signed (Monti	n, Day, Year)
3		17AD Ne	1 Shil		D47232		10 03	2011
	Ш	30. Name and address of person who cor	L. Nach I - here	- COO	Harrier &	4	that were	Sieni
Stat	e	31. Date filed (Month, Day, Year)	32 Registrar's Signa		/	- Cas	104	21901
Registra	ır	OCT 05 201	1 some	A. Marie				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First Middle, Last) 2. Date of Death Physician/ 9:55 Gloria Norma Cohn October 04.2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Casey House - Montgomery Hospice Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth Days (Month, Day, Year) 579-32-5002 **Director** 1 M 2 K F 83 08/08/1928 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 1 No Maryland Montgomery Silver Spring or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 14508 Homecrest Road 20906 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by Yes Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify. 3 X Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Frederick Davis Ida Sylvia Varsubsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brad Van Grack - Son 1813 Billman Lane. Silver Spring. Maryland 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of H Important: If ite any injury or oth once. 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) King David Mem. Grdns 10/09/2011 | Falls Church, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, MD 20904 11800 New Hampshire Ave., Silver Spring, 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Myocardial Infarction disease or condition Medical resulting in death) Examiner Odontoid Fracture Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 __ Live Birth 2 __ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pneumothorax 1 Yes 2 X No 3 Probably 4 Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 X Yes 2 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 X Accident 5 Pending Fall From Standing 09/19/2011 1 Yes 2 No Unk Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify)

Home

23.67 or Spring MD 10

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. determined Medical 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and tille of cert 29d. Date signed (Month, Day, Year) PO R143201 October 05, 2011 30. Name and address of person who completed cause of death (kem 23a) (Type, Print) Debrah Miller, CRNP, 1355 Piccard Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) State OCT 11 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month D. Whitney Coe October 2011 6:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Montgomery Wilson Health Care Center Gaithersburg 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F March 23, 1937 128-34-9933 New York Director 74 Yrs Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Gaithersburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20877 211 Russell Avenue, #42 14. Race - American Indian.

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Funeral Director 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status or i 1 Never Married 2 Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) University Librarian 5+ and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harold Dayton Coe Vera Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau (Brother) L. Dayton Coe 211 Russell Avenue, #42, Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 🖺 Burial 2 🗆 Cremation 3 🗆 Removal from State October 15, 4 ☐ Donation 5 ☐ Other (Specify) 2011 Oswego, New York 22. Name and Address of Facility DeVol Funeral Home Signature of Funeral Service Licenses M00689 10 E. Deer Park Drive, Gaithersburg, MD 20877 Party They the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirth, or high failure. List only one cause on each line. Immediate Cause (Final Vesatic faiture Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine cause. Enter Underlying requires that the death certificate be executed Cause (Disease or linjury

that initiated events resulting in death) Last

23b. Was decedent pregnant

g Unknown

27. Manner of Death

Natural

2 Accident
3 Suicide
4 Homicide

in the past 12 months?

2 TNo

Due to (or as a consequence of)

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Pregnant at time of death Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___

23d. Date of delivery Month

Black, White, etc

Specify: White

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 🗹 No 3 Probably 4 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

building, etc. (Specify)

24a. Was an autopsy performed?

4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

Onset and Death

28a. Date of injury 5 Pending

Other: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of (Month, Day, Year)

28c. Injury at 28d. Describe how injury occurred work?
1 \(\text{Yes} \quad 2 \(\text{No} \)

28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Investigation

determined

6 Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14. ROBERT BIRSCHOALH, WIL

04115 October 9, 2011 201 KUSSZLL AVENUE GAITHERS BURG, MIS 20277

State Registrar

physician a the burial-t

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Box 68760

P.O.

Records,

the Hospital or Attending Physician: Division of Vital

Physician/Medical

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Completed

Certificate:

Medical

the

Sompleted filled in by

IF FEMALE

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 02,2011 1830 Sylvia Charuhas Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Shadu Grove Adventist Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 26, 1927 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X Director 577-32-2966 84 Washington. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" any injury or other traumatic events. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Germantown 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21000 Father Hurley Boulevard, 20874 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates 3 → Widowed 4 □ Divorced Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Sales Salesperson 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Hannah Rose Michaelson Rubin Vinner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10822 Avonlea Ridge Place, Damascus, Maryland 20872 Jeffrey M. Charuhas - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 10/11/2011 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Aspiration Pneumonia Medical resulting in death) **Examiner** Pulseless Electrical Activity Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) as the bunial-transit Acute Respiratory Failure Due to (or as a consequence of) resulting in death) Last attending physician by Physician/Medical The law requires that the death certificate be Gastrointestinal Bleed (Non-Traumatic) P.O. Box 68760 IF FEMALE: for use yes, outcome of pregnancy

Live Birth 2 Petal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No
9 Unknown Day 5 Other (specify) Month detached signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Breast Cancer 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has balinector, page 2 sl autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific, Completed filled in by the funeral director, and the funeral director, the funeral director director, the funeral director director, the funeral director director director director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 2 X No Other: 1 2 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury X.Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 du October 07, 2011 D41162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vinu Ganti, M.D. 19529 Doctors Drive, Germantown, Maryland 20874 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 201^{Year} Carol A. Cann 13:18P. [™] Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 578-36-8388 81 **Director** 1 🗆 M 2 🔀 F July25,1930 Washington,DC Usual Residence of Decedent 28a-f shov 10a. State r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2827 Calverton Blvd. 20904 United States Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗖 No Specify 3 XWidowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4 on 5+) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important; If item 27 is marked other tha any injury or other traumatic event, the Nonce. Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mary Elizabeth Sale ည Roland Carl Eaton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard E. Cann -son 1046 Wintergreen Terrace Rockville, Maryland 20850 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metropolitan Crematory 10/10/2011 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Bonald WdreBorgwardt Funeral Home, PA Das 4400 Powder Mill Road Beltsville, Maryland 20705 1900 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between cause on each line Immediate Cause (Final Onset and Death Physician/ Intracranial Bleed disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Sician aper Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar for use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death signed by the atter Ectopic pregnancy in the past 12 ponths?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 4 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 ☐ Yes 2 💢 No 1 ☐ Yes 2 🔀 No mpletely filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospita 1 ☐ Yes 2 XNo ျှ Other: 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 5 Pending death. 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deatl 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

Registrar

State

10

29a. Certifier

only one) 29b. Signature and title of ca

30. Name and address of person who Rachel Vile,

M.D.

within 2

To the I

of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

29c. License number D58376

3 🗆 Certifying Nurse Practitioner: To the lest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2401 Research Blvd. Rockville, Maryland 20850

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month October 2011 Year Scidane Cameron Α. 11:12 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6008 Rosedale Dr. Prince George's Hyattsville If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 M 2 X F (Month, Day, Nov . 22 Jamaica,W.I. Director 050-80-9102 62 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Md. Prince George's Hyattsville 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 6008 Rosedale Dr. U.S.A. within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. þ 1 X Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔂 No Specify: Specify: Black "natural", Completed 3 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) I 2 College (1-4 or 5+) Nursing Assistant Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stanley Cameron Adlyn Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robinson (Daughter) 6008 Rosedale Dr. Hyattsville, Md. 20782 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Evergreen 10-15-11 Cemetery Brooklyn, N.Y. 21. Signature of Funeral Service Licenses Name and Address of Facility nambers Funeral 301 Cleveland A Crematorium P.A. erdale, Md. 20737 Home & Cremato ve. Riverdale, nam Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ AMYOTO disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury by the attending physician and arched for use as the burial tensit Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Day Year After this certificate has been signed by the a funeral director, page 2 should be detached it 9 Unknown 9 Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has tagging the funeral director in an 9 or 100 mans 2 or 100 ma autopsy performed? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Hospital Other: 욘 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes Accident 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Less Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie. 29c. License number 29d. Date signed (Month, Day, Year) ract Ol 0 D23743 Oct. 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin D. Weltz 7525 Greenway Center Dr. Greenbelt, Md. 31. Date filed (Month, Day, Year) 1 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOber D. Carthorne 10:20 A M Medical 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loc Examiner County of Death
HARLE tion of Death 1910 Funeral Security Number 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 💢 F 60 Months Hours Min. 06-29-1951 577-74-2872 Director Washington DC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he martinal anger. 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Charles Waldorf 1X☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4078 Bluebird Dr. 20603 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2X Married Completed by 2 **X** No 1 ☐ Yes If Yes. Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Divorced Black Specify. Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Day Care Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Cornelius Rousev Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald D. Carthorne/Husband 4078 Bluebird Dr. Waldorf, MD 20603 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 10-14-2011 Suitland, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald Taylor II FH 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ hens disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death been signed by the a should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I Completed filled in by the funeral director, page 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Yes 2 □ No Other: 1 Inpatient 2 FR/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Time of 28d. Describe how injury occurred Natural injury 5 Pending Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 10050883 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ahia 15 TOO POINT LONKS leon dtown My 20650 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6 2011 Month 10 06 Carmela DiDomenico 3:54 P™ 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 8810 Walther Blvd. Apt. Baltimore Parkville 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2 🖼 F Months Days Hours Min 90 Yrs. 133-05-2146 2/3/1921 NY Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Parkville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8810 Walther Blvd. Apt. 1521 21234 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ☐ Yes 2 1 No 1X Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🕅 No Specify. White Specify: 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Executive Secretary Computer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Filippo DiDomenico Teresa Guarino 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amanda McFadden - Niece 510 Camilla Street, Havre De Grace, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/14/2011 Middle Village, NY St. Johns Cemetery Funeral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, PA 111 S. Queen Street, Rising Sun, MD 21911 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCU D Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 No 1 ☐ Yes to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

executed ending physician and use as the burial-trans Box 68760, certificate be for signed by the a Ö ۵. Division of Vital Records, has this certificate the Hospital or Attending Physician: After thi funeral of

Examine Physician/Medical þ Completed Be ဥ within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician

/Medical

Director

þ

Completed

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Examiner

Funeral

Director

Pages 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examit or must be retified at

Department of Health are Important: If item 27 is any injury or other trau

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

Certification:

Medical

25. Was case referred examiner?
1 Yes 2 No
27 Manner of Death

29a, Certifier

1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide 4 🗌 Homicide

Date of Injury (Month, Day, Year)

28b. Time of

28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 □Yes 2 □No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number 058646 29d, Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Monias 31. Date filed (Month, Day, OCT

Walther 8008 Registrar's Signature

			For State	State of M	larylan		artment of I		d Menta	al Hygien	е		
			Registrar			Cei	tificate of I	Death		Reg. I	10. 20	1 33981	
	Physicia	ın/	Vana (II 7), ahmana							2. Date of Death Month October 06, 2011 3. Time of Death 4:40 p			
	Medic Examin										1c. County of Dear		
	LAGIIII	CI	5225 Pooks Hil	,	313N			Bethesdo				tgomery	
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	Director		220-40-3094	1 L M 2 L9 F	83	Yrs.	Worth's Days	Hours	In. Jun	e 15,1	928	untry) Poland	
	nd how	5	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits	
	faryla Ba-f s	ect	Maryland Montg	omeru				Bethes	da			1 ☐ Yes 2 🎗 No	
	the N	ä	10e. Street and Number				10f. Zip Code			10g. (Citizen of What Co	ountry?	
	s 238	Funeral Director	5225 Pooks Hil	'L Road, #1	313N			20814			и	.S.A.	
	death r item iner n		11. Marital Status	12. Was Decedent I Armed Forces?		3. 13. \	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? ın, Mexican, Pu	(Specify Yes uerto Rican, e	or No-	14. Race - Ame Black, Whit		
39	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🗶 If Yes, Give Year or Dates.	No	1	☐ Yes 2 🗓 No	Specify:			Specify:	White	
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ž	should and Me is marl aumati		19a. Informant's Name/Relationship		sicy	19h Mailir	g Address (Street	and Number or					
	and 2 sh Health a tem 27 is		Isaac Dickmann -	Spouse			Pooks Hi						
ore,	of He fitem		20a. Method of Disposition	•		lace of Dispo	sition (Name of natory or other plac		Date	-	Location - City or		
<u>E</u>	Page 1 ment of 1 tant: If it iury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Domation 5 ☐ Other (Spec			-	morial G		/07/20	011 0	lney, Mo	vryland	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fundal Sarvior Lich	Moo Zo	9	22 11	Name and Addres	ss of Facility Hampshi	Hines- re Av	Rinald Sil	i Funera Ver Spri	l Home, Inc. Ing. MD 20904	
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\$	Medical Examiner		resulting in death)	Due to (or as									
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ROX	death ce he attend ed for us	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal	death 3	Ectopic pregnand Other (specify)	:y			23d. Date of de Month	livery Day Year	
ă	he de y the ched	Physician/Me	1 🗌 Yes 2 🔀 No 9 🔲 Unknown	9 Unknown	it tillle of de	eatri 5 L	Other (specify)					ou, rou	
J.	requires that the death certifica been signed by the attending pl should be detached for use as t	by PI	Part II. Other significant conditions		ut not resu	ulting in the u	nderlying cause giv	en in Part I.	236	e. Did tobacco	use contribute to	the cause of death?	
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<u>ra</u>	ician certifi rector	m	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		-	Otho	ace of Death (C	heck only on	e)			
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DIVISION OF	r Atte	ertificate:	3 ☐ Suicide 6 ☐ Could not lead of the second secon				et, factory, office				nd Number or Ru	ral Route Number,	
5	oital o urs af ral Di	a C								or Town, Stat			
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the Romeral director, After this certificate has been signed by the Romeral director, page 2 should be detached the detached filled in by the funeral director, page 2 should be detached.	Medical	(Check 2 L. Medical Exam	ysician: To the best of niner: On the basis of ex rse Practioner: To the	xamination	and/or investi	gation, in my opinic	n death occurre	ed at the time	date and place	e and due to the	cause(s) and manner stated	
	Vithi To the	- 1	29b. Signature and title of certifier				29c. License	number			ate signed (Month		
Ĭ	/2		decor	eee	m	J		3344	2	0	ctober 0	6, 2011	
			30. Name and address of person who	completed cause of de	eath (Item 2	23a) (Type, Pi	nint)	i+0 11	1 Da-	huilla	Manila	ad 200EA	
	State	e	Alan Pollack, M. 31. Date filed (Month, Day, Year) OCT 0 201	2., 1∠01 S 32. Registra	r's Signatu	ire #	Roda, St	me III	, KUC	KVILLE	, muryka	nu 20074	
	Registra	r	001 0 7 201	Demua	, A.	gar							

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #105-f Per FH G923 1/04/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 0 Mildred Louise Dyson $20\overset{\circ}{1}\overset{\circ}{1}$ M 2:00P Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Thomas More Nursing Home Prince Georges Hyattsville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours January 30, 1937 219-36-8176 Director 74 Maryland Usual Residence of Decedent 28a-f show 10b. County Charles 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Ironsides MD Prince Coorges Oxon Hill 1 Yes 2 No 0 10e. Street and Number 4600 Poplar Springs RD. 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20643 20745 USA items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Black, White, etc ģ 9 Maryland 21215-0036 1 Yes 2 No Specify: White and Mental Hygiene. Specify 3 Divorced 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Public Schools Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elizabeth Bowie George Dyson,Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744 Anna Gardiner/Sister 7902 Prince Georges Drive, Fort Washington,MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 10/13/2011 4 Donation 5 Other (Specify) Ironsides, Maryland Old Durham Cemetery 21. Signature of the al Service 22AREHARTGECHOUS FUNERAL HOME, P.A. M01458 211 St. Mary's Ave. La Plata,MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami signed by the attending physician and a betached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy 1 Yes 2 No 1 ☐ Yes 2 🔯 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2**X** No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Investigation 6 Could not be Accident ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of continu 29d. Date signed (Month, Day, Year) .0006368 October 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1835 University Blvd. #208 Hyatsville, MD 20783 Dr. Ajit Kurup

State

Registrar

31. Date filed (Month, Day, Year)

OCT

12

Registrar's Signature

			For State of Marylan				Mental Hy	giene		
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of De	eath		Reg. No. 2 ()	<u> 11 33986</u>	
	Physicia Medi		Oleta Fewell Dahbour				2. Date of De Month Oct 5.		3. Time of Death	
and the same	Examir		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L	ocation of Death		4c. County of	11:00 A. ™	
- Jane			Collingswood Nursing HOme		Rockville			Montgom		
	Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. II		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th	9. Birthplace (State or Foreign Country)	
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	and show I at	٥		y, Town or Lo	cation				10d. Inside City Limits	
	Maryl 28a-f otifiec	Director	Maryland Montgomery	Rockvi]	le le				1 ☐ Yes 2 👿 No	
	a or 2	٥	10e. Street and Number		10f. Zip Code			10g. Citizen of Wh		
	h with	Funeral	299 Hurley Ave		20850)		United S	States	
	r iten iner r				Vas Decedent of Hisp Yes, specify Cuban,	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race -	American Indian, White, etc.	
36	al", o	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	1	☐ Yes 2 🙀 No	Specify:	,	Specify:		
9	hours natur iical I	Completed	15. Decedent's Education	16a. Deced	ent's Usual Occupation	on		16b. Kind of Busi	White	
218	in 72 e. nan "	dmc	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k	ind of work done dur NOT use retired)	ing most of work	ing	100. Killa of Basi	iess ilidustry	
2	d with ygien her ti	Be C	12		Procurement	Agent		U.S. Navy		
anc	ntal H ed ol	70 B	17. Father's Name (First, Middle, Last) Noah Alonzo Fewell		1			Maiden Sumame)		
Ž	ould k id Me mark matic	ľ.	19a. Informant's Name/Relationship (Type, Print)	T			Belle Ri			
\mathbf{z}	12 shulth ar 27 is rtrau		Omar H. Dahbour (son)		g Address (Street and				e, Zip Code)	
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E	Page nent c ant: If			emetery, crem ee Crema	atory or other place)		5, 2011	Clinton,		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral includes	22.	Name and Address	of Facility Lee	Fineral H		3 Old Alexandria	
ш	2 2 E 10 10		1/4 Detat 10015		rerry Koad.	Clinton.	MD 20735		O Old Alexandi la	
			23a. Part. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	h. Do not ente	the mode of dying, s	such as cardiac	or respiratory an	rest,	Approximate Interval Between	
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<u>о</u> .	that the	by PI	Part II. Other significant conditions contributing to death but not resu	ulting in the un	derlying cause given	in Part I.	23e. Did to	bacco use contribu	te to the cause of death?	
ds,	quires an sign uld be	edt	Coronaly Arten	DC	50220) /	1 🗆 🕆	Yes 2 No 3	☐ Probably 4 ☐ Unknown	
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5	Physi this c all dire	<u>٩</u>	1			4 X Nursing Ho	me 5 🗌 Resid	ence 6 Other (S	Specify)	
ם יי	ding th. After fune	Certificate:	1 Natural 5 ☐ Pending (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 1 Yes	3 2 □ No	28d. Describe h	ow injury occurred		
SIO	Atten ar dea ector: by the	ŧΙ	3 ☐ Suicide 6 ☐ Could not be	me, farm, stree			28f Location (S	treet and Number o	r Rural Route Number,	
Division of	tal or		building, etc. (Specify)				City or Tow	n, State)	Tratarrioute Hamber,	
	To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	29a. Certifier (Check only one) 29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	thin 2 the 1 the 1 the 1 the 1	— г	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	= > 2 8		29b. Signature and title of certifier	NO	29c. License nu			29d. Date signed (IV	onth, Pay, Year)	
		}	30. Name and address of person who completed cause of death (Item)	23a) (Type Pri		6243		10/0	10011	
			Sayed ElSayvad, M.D. 10110 Molecular I		,	kville M	D 20850			
	State	е	31. Date filed (Month, Day, Year) 2011 22. Registrar's Signature 2011	ire /						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ronald Cooper Edgar 2011 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9 ENERAL HOSPITAL CAMBRIDGE DORCH ESTEX DORCHESTER Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye) Feb. 20, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year 1 M 2 □ F Months Days Hours Min. 220-32-1474 75 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, It a Modical Evantimer must be notified at MD Dorchester Director Cambridge 1 ☐ Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4786 Maple Dam Road 21613 USA Baltimore, Maryland 21215-0036 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No ģ Specify. Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) agriculture farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leroy B. Edgar Margaret Shenton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara M. Edgar 4786 Maple Dam Road, Cambridge, MD wife 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department o Important: If any Injury or 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State East New Market Cem. East New Market, MD 4 ☐ Donation 5 ☐ Other (Specify) 10/9/11 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vascular **Physician** accident 6 mons /Medical Due to (or as a consequence of). Examiner th leroscientic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Yea 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ZWO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division of Vital Records,

RONALD

EDGA,

State Registrar 29b. Signature and title of certifier

atricia

31. Date filed (Month, Day, Year)

100 Bramble

29d. Date signed (Month, Day, Year)

Cambridge MD

and manner stated.

ddress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

lohn5on

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend#3perphysician10/19/11ccdohbb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Francis Aloysius Fenwick A M October 10 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 / 9 / 1939 Birthplace (State or Foreign Country) **Funeral** Days Hours **№** M 2□ F Director 220-34-7935 72 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f show Examiner must be notified at Director 1X Yes 2 □ No MD St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death N Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23: any injury or other traumatic event, the Medical Examiner must gorice. by Funeral 20795 Willows 20653 Road USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: SpeciaBlack 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Trucking <u>Self- Employed</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Green Elizabeth Fenwick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Fenwick/ Wife P.O. Box 391 Lexington Park MD 20653 to of Disposition (Name of Date 20c. Location - City or Town, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Immac.Church Cem. 10/15/2011 Lexington Park, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd. Waldorf, MD 20601 23a. Part1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician TEMI /Medical Due to (or as a consequence of): Examiner ardiae Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to for as a nonsequence of: The law requires that the death certificate be executed Due to (or as a consequence of): TRANCIS A. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 40 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attend 24 hours after death. Funeral Director; / 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25500 trayor

State

Registrar

31. Date filed (Month

Year)

12

32. Registrar's Signature

Breun

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Month 2124 Erich Fehrs Octobe /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cambridge Dorchester General Darchaster Hospita 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex . Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country)
New York 8. Date of Birth (Month, Day, Year) 1 ☑ M 2 □ F Months Days Hours Min 089-32-9152 Director 71 May 10, 1940 Usual Residence of Decedent 10a. State 10c. City Town or Location 28a-f show 10d. Inside City Limits event, the Medical Exauditer must be notified at Director Dorchester 1 ☐Yes 2 X No Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 201 Buena Vista Avenue permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 amy injury or other traumatic event, the Medical Evals for must once. Completed by Funeral 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 11 Marital Status 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1¶Yes 2∏No
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Year or Dates:1960-64 1 Never Married 2 Married 1 ☐Yes 2 No Specify. Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) assistant manager grocery store 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Karl Fehrs ည Kathe Dambolt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Fehrs wife 201 Buena Vista Ave., Cambridge, MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crematory of Delmarva 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/11/11 Delmar, DE 21. Signature of Funeral Service 1 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 minuter Myocardia /Medical Due to (or a la consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed and burial-t Due to (or as a consequence of): attending physician for use as the buria Physician/Medical If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 1 ☐Yes 2 ☐No 5 Other (specify) ned by the a 9 Unknown signed by the detach The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performe certificate 1 ☐Yes 2 ☐No 1 ☐Yes 2 🗷 No Hospital or Attending Physician: r this certificaral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. after death Director; of in by the f 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ∏Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

Baltimore, Maryland 21215-0036 P.O. Box 68760, Division of Vital Records, To the Hospital on within 24 hours aft To the Funeral Discompletely filled in Medical (29b. Signature and title of certifier ax 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 468 M.D. 31. Date filed (Month, Day, Year) State 33. Registrar's Signature Registrar

29d. Date signed (Month, Day, Year) 050804 Cambridge, MD 31613

			for State Registrar	State of Maryla		artment of I <i>tificate of I</i>		•	giene Reg. No. 201	1 33990	
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12,00	Exami		4a. Facility Name (if not institution, give sa	,			r Location of Dea	th	4c. County of Death		
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ary	should be file h and Mental H 7 is marked of traumatic ever		19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street	and Number or R		; City or Town, State, 2	Zip Code)	
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Baltimore,	0 4- 1		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🛣 R	emoval from State		natory or other plac		Date	20c. Location - City		
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	Stat	te	Gary Fisher, M.D., 31. Date filed (Month, Day, Year)	5530 Wisco		enue, "11	ou, chev	y cruse,	mucycunu	20013	
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			State Registrar			Cei	tificate of E	Death		Reg.	No. 201	3399
Phys	sicia	n/	Decedent's Name (First, Middle	(Last)					2. Date o		Day Year	3. Time of Death
M	edic	al	Dorothy		_		· · · · · · · · · · · · · · · · · · ·			ember	28 2011	7:10 AM
Exa	ımin	er	4a. Facility Name (if not institution,				4b. City, Town, or		f Death		4c. County of Deat	
Fune	ral		Pineview Nur 5. Social Security Number		1 <mark>.</mark> 7. Age (In yrs. la	ast hirthday)	CLir If Under 1 Year	ton	24 Hrs. I o D-4		Prince (
Direc			220-28-6947	1 □ M 2 🔀 F	79	Yrs.	Months Days	Hours		Bay Yea	1932 Mar	thplace (State or Foreign untry)
7 MC +	J		Usual Residence of Decedent			***			1149	207.	- J J Z FIGI	yland
yland	D 0	ctor	10a. State 10b. County	_		y, Town or Lo						10d. Inside City Limits
e Ma r 28a		Dire	MD Princ	e George	S		Clinton					1 🄀 Yes 2 □ No
ith th	2	ral					10f. Zip Code			10g.	Citizen of What Co	untry?
ems		Funeral Director	9106 Pinevie	12. Was Deced	lent Ever in LLS	3 13 1		735	in? (Specify Vec or	No	USA	
G ter de		by F	1 Never Married 2 Marri	Armed Ford	ces?	1-			in? (Specify Yes or Puerto Rican, etc.)	VO-	14. Race - Ame Black, White	
DO3	4		3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Date		1	Yes 2 X No	Specify:			Specify: Bla	ack
21215-0036 within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho ier than "hatural", or items 23a or 28a-f sho ier than "hat hen ordified a		Completed	15. Deceden (Specify only highes	's Education it grade completed)			ent's Usual Occupa		of working	16b.	. Kind of Business	Industry
121 thin 7 she.		팃	Elementary/Seconday (0-12) 12th	College (1-4	4 or 5+)	life. Do	O NOT use retired)	annig mode	or working			
nd 2 filed will all Hygiv d other		Be (17. Father's Name (First, Middle, La	lst)			Clerk	10 Madha	r's Name (First, Mide			Government
		잍	Oliver E.	,					rs Name (First, Midd Lry E. L		,	
Maryla 2 should be th and Men 27 is marke traumatic			19a. Informant's Name/Relationshi			19b. Mailin	g Address (Street a		or Rural Route Nur			Cade
			Michelle F. G	reen/Dau	ghter							
Baltimore, I permit. Page 1 and 2 Department of Health (mg) rtant: If item 2 any injury or other t			20a. Method of Disposition 1 X Burial 2 ☐ Cremation		20b. P	lace of Dispos	sition (Name of atory or other place		Date		Location - City or	
Limo Page tment o tant: If			4 Donation 5 Other (Sp	ecify)	Har				0/8/11	La	ndover,	MD
Baltimo permit. Page Department of	ig.		21. Signature of Funeral Service	7 /		22.	Name and Address	s of Facility	AUstin	Roy	ster Fu	neral Home
- "ジン		\dashv	* Vaulance		M00969) 38	321 14th	Str	eet,NW,	Wash	ington,	DC 20011
2			23a. Part 1. Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final	lly one cause on each	n line.			1	ardiac or respiratory	arrest,		Approximate Interval Between
Fnysicia ∤ Medic	_		disease or condition resulting in death)	a. \5c\	nemic	COSC	home op	atey				Onset and Death
Examin	_				as a consequence	,	alial .	· C	action			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		as a conseque		COLLA	A C LOCA	C.C. 10 V			
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exectian a	-	<u></u>	resulting in death) Last	Due to (or	as a consequ	nce of):	1					
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box decth c he atten ed or u		Physician/M	23b. Was decedent pregnant in the past 12 months?	1 🗆 Live Bir	rth 2 Fetal int at time of de	death 3	Ectopic pregnancy Other (specify)			83	23d. Date of deli Month	very Day Year
he de y the iched		nys!	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknov		5411 5 🗆	Other (specify)			- i	111011111	700
that the period be determined by	ľ		Part II. Other significant condition	s contributing to dea	th but not resu	Iting in the un	derlying cause give	n in Part I.	23e. Di	d tobacco	use contribute to	the cause of death?
dS, quires en sig		Be	Sepsis						1	Yes 2	2 🗹 No 3 🗆 Pr	obably 4 🗆 Unknown
ecords, e law requires s has been sig ge 2 should b		ble	Stage 10	Jecubi	tus i	elcer			24a. W		24b. Were aut	opsy findings available
The L		Completed by	O						pe	topsy rformed? es 2 ☑1	death?	ompletion of cause of
VICAL ysician: s certific director,		e a	25. Was case referred to medical examiner?	Hospital:					(Check only one)			
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ding th. After		Certificate:	1 Natural 5 Pending 2 Accident Investiga	(Month,	Day, Year)	injury	28c. Injury a work? M 1 🗆 Ye	at es 2⊡N	28d. Describ	e how inju	iry occurred	
Attendir or death. ector: Af by the ful	9		3 Suicide 6 Could no	t be 28e. Place of	Injury - At hom	ne, farm, stree	et, factory, office			(Street a	nd Number or Rura	al Route Number
tal or rs after all Dir	15		- Commondo determina	building,	, etc. (Specify)				City or 7	own, Stat	e)	a riodic rambol,
To the Hospital or Attending Physician: The law requires that the det th certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending proppleted filled in by the funeral director, page 2 should be detached or use as	1.6	Medical	29a. Certifier 1 Certifying P	hysician: To the best	t of my knowle	dge, death oc	cured at the time, o	late and pla	ace, and due to the	cause(s) a	and manner as stat	ed. ause(s) and manner stated.
thin 2 the f	ž		offit offe) 3 - Certifying N	urse Practioner: To	the best of my I	knowledge, de	ath occurred at the t	ime, date a	nd place, and due to	the cause	(s) and manner as s	tated.
_ = = = W		-	9b. Signature and title of certifier	~~			29c License n	umber	32	29d. Da	ate signed (Month,	Day, Year)
		2	io. Name and address of person wh	o completed series	of doath //	22a) (Time 12:		7 5 5	73 F	100	1 real 57	2011
			11 - 61 .	eay mil	USSS	Smil	the Are	Ste	203 B	eltra	Leve, Md	21709
	tate		Date filed (Month, Day, Year)	22. Regis	strar's Signatul							
Regis	trar		OCT 11 20	Sente	v 1.	park						

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dianne Irene Farrell oct.7,2011 Year 0657 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Months Days 107377947 Hours Director Germany 090-42-7455 63 Yrs. Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Silver Spring Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 1308 Caddington Avenue 20901 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc.
White 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ANo Specify: 3 Midowed 4 ☐ Divorced Completed Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Collection Co. Collection Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Irene Fitzgerald ည Thomas Farrell 19a. Informant's Name/Relationship (Type, Print) SLep-Patricia DeLorenzo/sister step-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1308 Caddington Avenue Silver Spring, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation Other (Specify) Chesapeake Crem. 10/11/2011 Beltsville, Md 21. Signat re PHILTP ADSRINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Chronic obstructive pulmonary disease Medical resulting in death) Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) 0 To the Hospital or Attending Physician: The law requires that the death certificate be executed Encephalopathy and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery in the past 12 months?

1 Yes 2 No Pregnant at time of death Month been signed by the a should be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available page 2 s has prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy within 24 hours after death.

To the Funeral Director: After this certificate I

Geopoleted filled in by the funeral director, page performed? Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗶 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 XNatural 5 Pending Accident Suicide Investigation М 1 🔲 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ham D60826 Oct.7,2011 30. Name and address of person who completed cause death (Item 23a) (Type, Print) 1500 Forest Glen Road Silver Spring, Md 20910 Kshama Garq MD 31. Date filed (Month, Day, Year 32. Registrar's Signature State OCT 11 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \(\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Frances Jeannette Fitzgerald Medical ۵ 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ai **Funeral** 7. Age (In vrs. last birthday If Under 24 Hr 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🏝 F 578-18-3517 Hours 01/08/1922 Director 89 Washington, DC Usual Residence of Decedent 28a-f show 10a State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Salisbury 1 X Yes 2 □ No Wicomico 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? Funeral 23a 905 W. Schumaker Drive 21804 USA items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō ð 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Baltimore, Maryland 212/15-0036 "natural", 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed White is marked other than "naturaumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Law Firm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. 2 Julius Louis Loehoefer Elizabeth Frances Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Patricia F. Graves/Daughter 11415 Newport Bay Dr., Berlin, MD 21822 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ArlThotonatNationat 4 Donation 5 Other (Specify) 11/8/2011 Cemetery Arlington, VA 21. Signature of Funeral Service 22 Name and Address of Facility Holloway Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physicin Onset and Death OBSTRUCTIVE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) as the burial-trans and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) been signed by the atte should be detached for in the past 12 months? Day Pregnant at time of death Month Vear Yes No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 s autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page performed? Yes (2 \(\) No 1 🗌 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: မ 1 Yes ER/Outpatient 3 DOA HOSPICR 1 Inpatient 2 I Other (Specify) ☐ Nursing Home 5 ☐ Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending ☐ Accident Investigation M 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signat State 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month OCt. Naomi Bernice Freeman 0120 М 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign (Month, Day, Year) -29-1934 577-46-3360 Months Days Hours Director Yrs Washington DC Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at Director 10d. Inside City Limits DC Washington 1 Tes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a1317 West Virginia Ave. NE 20002 USA items be filed within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: "natural" 3 XWidowed 4 ☐ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, <u>ithe Men</u> any injury or other traumatic event, <u>ithe Men</u> Elementary/Seconday (0-12) College (1-4 or 5+) Gov't Printing Office Inventory Clerk 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Reeder Lehmon Margaret West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda D. Smith/Daughter 4909 70th Ave. Hyattsville, MD 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial Cem | 10-14-2011 | Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of FacilitRonald Taylor II FH 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Thysician/ arolions disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Securately list routhing if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ner Exami the attending physician and thed for use as the bunal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 1 L Yes 2 L 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has t 24a. Was an autopsy performe ☐ Yes 2 🖪 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 2 No ၉ 1 Tes Other: 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

who completed cause of death (Item 23a) (Type, Print)

			Please Type or Print i	in Black Indelible Inl	c. Ensure All C	Copies Are	Legible.			
			State of Maryl	land / Department of F		ital Hygiene)			
			1 - State Amend#23a per Dr.10-12-1	1 tt Certificate of L	Death	Reg. No	<u>. 201</u>	33995		
parents,	Physicia Medi			FAKRODDIA		Date of Death Month	ay 20//	3. Time of Death 8:304 M		
	Exami	4a. Facility Name (if not institution, give street and number) 120/3 MONTROSE PARK PL - ROCKVILLE 4b. City, Town, or Location of Death MONT								
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 XF 7. Age (In y 73 Usual Residence of Decedent	yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. I Hours Min.	Date of Birth Month, Day, Year	9. Bird	thplace (State or Foreign untry): INDIA		
	1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ector		ROCKVILL	E	-		10d. Inside City Limits 1 Yes 2 □ No		
	vith the M 23a or 28 st be not	Funeral Director	10e. Street and Number 12013 MONTROSE PAR	10f. Zip Code		10g. Ci	itizen of What Co	ountry?		
10	r death v or items niner mu	by Fune	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S. 13. Was Decedent of Hi	spanic Origin? (Specify n, Mexican, Puerto Rical	Yes or No- n, etc.)	14. Race - Ame Black, White			
-0036	ours afte atural", c cal Exan	eted b	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 Divorced 1 ☐ Yes 2 No If Yes, Give Year or Dates.	1 Yes 2 No		16h K		SIAN		
21215-0036	ed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f sho ant, the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give kind of work done of life, DO NOT use retired)	luring most of working			INCLUSION DEPTOR		
Maryland 2	ild be filed w Mental Hyg narked othe	To Be	17. Father's Name (First, Middle, Last) SYED TMAM	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	18. Mother's Name (Fire	st, Middle, Maiden	A			
ary	should and Mi is mar		19a. Informant's Name/Relationship (Type, Print) DAUGH	TER 19b. Mailing Address (Street a				code)20852		
	and 2 s Health a tem 27 i		NILOFER NABIFAKRODO					VILLE MO		
Baltimore,	0		1 Burial 2 Cremation 3 Removal from State	Db. Place of Disposition (Name of cemetery, crematory or other place)	DEN 10/10	2	ocation - City or			
altir	ort		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	L-FIRDAUS ME 22. Name and Addres	s of Facility ADE	1 1 1 1 1				
m	Dep Imp any	7.	I hillip Bell &	1242 EA	SY-ST. W	SCODBRIL	DGE V	A. 22191		
	Physician/		23a. Part 1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Jeath. Do not enter the mode of dying	g, such as cardiac or res Railu	piratory arrest,		Approximate Interval Between Onset and Death		
ميد	Medical Examiner		resulting in death) Due to (1) is a cons	sequence of):	N. C.C.	050		1994		
		ner	Esqueritially list conditions, if any, leading to immediate cause. Enter Underlying	sequence of):	dire	10-6		1980		
	se executed cian and ourial-transit	Examine	Cause (Disease or iinjury that initiated events c.	tes				(42		
0	be exe sician burial-	<u></u>	resulting in death) Last Due to (or as a cons	sequence oi).						
68760	tificate ng phy as the	Medi	IF FEMALE:							
Box 6	requires that the death certificate be been signed by the attending physici should be detached for use as the bu	Physician/Medic	23b. Was decedent pregnant in the past 12 months?	Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify)			23d. Date of del Month	livery Day Year		
P.0	that the or ned by the e detache		Part II. Other significant conditions contributing to death but not	resulting in the underlying cause giv	en in Part I.	23e. Did tobacco u	use contribute to	the cause of death?		
ds,	equires een sig ould b	ted	Asthma Hypertension			1 🗌 Yes 2	^	robably 4 🗌 Unknown		
Division of Vital Records,	38	Completed by	Hypertension			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No			
ita	ician; certific rector,	Be	25. Was case referred to medical examiner? Hospital:	Othe	ace of Death (Check only					
of V	g Physer this eral dii	e: To	27. Manner of Death 28a. Date of injury	28b. Time of 28c. Injury	at 28d.	5 X Residence 6 Describe how injur		ify)		
on	ending eath. or: Afte he fun	ficat	1 Natural 5 Pending (Month, Day, Year, 2 Accident Investigation 3 Suicide 6 Could not be		? Yes 2 □ No					
Divis	Hospital or Attending I 24 hours after death. Funeral Director: After sted filled in by the funer	al Certificate:	4 Homicide determined 28e. Place of Injury - A building, etc. (Spe	at home, farm, street, factory, office ecify)		ocation (Street an City or Town, State		ral Route Number,		
	To the Hospital or Attending Physician: The k within 24 hours after death. To the Funeral Director: After this certificate h completed filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physician: To the best of my kn (Check only one) 3 Certifying Nurse Practioner. To the best of examinar.	ation and/or investigation, in my opinio	n, death occurred at the t	ime, date and place	e, and due to the	cause(s) and manner stated.		
	To the within 2 To the comple		29b. Signature and title of centifier	29c. License		29d. Da	ite signed (Month	n, Day, Year)		
	1		30. Name and address of person who completed cause of death (Tem 23a) (Type Print)	4745	(MA	2011 2011		
	99		MELISSA FRIEDLAN	M.D. 2415 M	USGROVE	ERD. #	#105, S	ILVERSPRIM		
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Sig	Mature (

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 -** For State Registrar 3996 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201^{Year} 2:10p Josephine Hannah Ginegaw October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Rising Sun Calvert Manor Healthcare Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 15, 1922 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Days Min. Hours 89 Yrs Director 220-03-8234 May Usual Residence of Decedent 28a-f show More Marked Hygiene, narked other than "natural", or items 23a or 28a-f shot narked other than "natural", or items 23a or 28a-f shot naric event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10d. Inside City Limits 10a, State 10c. City, Town or Location Director 1 🗌 Yes 2 🏋 No Rising Sun MD Cecil 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21911 1881 Telegraph Rd. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private School Dorm Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bessie C. Moore Luther Ragan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Duncan Ln. Bryn Mawr, PA 19010 Judy Grant Malkin - Daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or of once. cemetery, crematory or other place) 1 Neurial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/14/11 Rising Sun, MD Brookview Cemetery 22. Name and Address of Facility
R.T. Foard Funeral Home, P.A.
111 S. Queen St. Rising Sun, Signature of Funeral Service Licen Part 1) Enter the disease, or combinations that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lower extremity Physician/ cclusion right TEDIAL disease or condition Medical resulting in death) Examiner dominal HORTIC Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ tension 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 2 🗌 No 1 Tyes Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? A Natural 5 Pending 2 🗆 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 🞇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

Registrar

DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registr

29c. License number

Rising

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 Year Physician/ OCTOBER 8 CORDELIA GILES GRAY 10:40 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 532 OAK STREET ABERDEEN HARFORD 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Months Days Hours Min 213-28-0569 78 Yrs **Director** MARYT AND Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location death with the Maryland 10a. State 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No MARYLAND HARFORD ABERDEEN 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? items 23a Funeral 532 OAK STREET 21001 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: BLACK Specify: "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the NURSING ASSISTANT VA HOSPTIAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental I important: If item 27 is marked o any injury or other traumatic eve once. ည JAMES HENRY FINNEY LOITIE TRADER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BREWSTER GRAY (HUSBAND) 532 OAK STREET, ABERDEEN, MARYLAND 21001 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State ATLANTIC CREMATORY 10/11/11 GLEN BURNIE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility LISA SCOTT FUNERAL HOME 552 LEWIS STREET, HAVRE Signature of Funeral Service Licensee -cet MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Shysician/ pancreatic cancel disease or condition 13 months Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or impury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: be detached for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Month Year Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Viabetes 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 🗌 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home ★ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred **Na**tural 5 Pending work? 1 🗌 Yes 2 No 2 Accider
3 Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 [3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifu

Prashant Shukla, 31. Date filed (Month, Day, Year) 0CT 11 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Omnibus t. Shukb M 15 S. Parke St.

29c. License number

4 400

00048050

Aberdeen MD

29d. Date signed (Month, Day, Year)

10/10/11

21001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Day Physician/ El 12abeth 21:32 October 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Mon Gomen Huspital olne If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Days Hours 82 Director 1 🗆 M 2 🗙 F 09/08/1929 Virginia 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No Maryland Montgomery Wheaton ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 1 and 2 should be filed within 72 hours after death with 3120 Helsel Drive 20906 u.s.A 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 [X] No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ıral", or iten I Examiner ı Black, White, etc. Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: "natural" 3 X Widowed 4 Divorced White Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than alth and Mental Hygiene. 27 is marked other than r traumatic event, the M. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Joseph Judson Williams, Jr. Nellie Hoover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. John Korman - Cousin 1813 Plain View Road, Richmond, Virginia 23238 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🕱 Removal from State W. Hampton Mem. Park 10/07/2011 | Richmond, Virginia Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee many MO1524 11800 New Hampshire Ave., Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ hvoniz Juluoran disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: g physician and as the burial-transif To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No been signed by the atter should be detached for Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an in 24 hours after death.

The Funeral Director; After this certificate has be the felled in by the funeral director, page 2: autopsy death? Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: ၉ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chintu Sharma, M.D.

31. Date filed (Month, Day, Year)

D 69086

200 Memorial Avenue, Westminster, Maryland 21157

Ochober 2, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #19b Per INF C920 10/31/2011 JH
State of Maryland / Department of Health and Mental Hygiene 33999 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ GINSBERG Dorothy 6:30 P October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver_Spring Riderwood Skilled Nursing Facility 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 TYF Months Hours 101-12-8009 Director an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10c. City, Town or Location Silver Spring 10a. State 10d. Inside City Limits Director Montgomery Md. 1 Yes 2 XNo 10e. Street and Number Zip Code 20904 10g. Citizen of What Country? 3160 Gracefield Rd. Funeral U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc <u>چ</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of Fisher Abraham Edith Groden other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
106 Irving St., Silver Spring, MD 20904
14217 Northwyn DR.

20b. Place of Disposition (Name of Date 20c. Location - City or Town, S 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s of Health Susan Ginsberg / daughter 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) Department of Important: If it any injury or o once. 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) emple Hadas Israel Oct. 11, 2011 New Castle, Pa Porchinsky Hebrew Funeral Home MOLOUS 254 Carroll St., NW, Washington, DC 20012 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic Obstructive Pulmonary Disease Physician/ years Medical resulting in death) Examiner Sequentially list conditions, Examine Due to lor as a consequence of than, heading to transdictions. Enter Underlying Cause (Disease or linjury that initiated events death certificate be executed Due to (or as a consequence of) resulting in death) Last physician as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a Yes 2 X No 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Congestive Heart Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 2 🗌 No Yes 2 V No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 1 Yes 2 X No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury work? 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Completed filled in by 4 Homicide determined Medical 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nufse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) Oct. 9, 2011 D 24035 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silver Spring, Md. 20904

State

Registrar

E.S. Machado, MD

1 1 2011

31. Date filed (Month, Day, Year

backer

3110 Gracefield Rd.,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ PEARL VIRGINIA GOSS OCTOBER PO 20 I'T 3:19 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPICE OF QUEEN ANNE'S QUEEN ANNE'S CENTREVILLE 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Hours JUNE 24, 1921 PENNSYLVANIA 195-22-4424 90 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MARYLAND QUEEN ANNE'S CENTREVILLE 1X Yes 2 No 10e. Street and Number ms 23a or must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 104 TILGHMAN AVE. APT.121 21617 UNITED STATES death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces Black, White, etc. ö þ 1 Yes 2 No 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE Completed 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 WILLIAM BARR NORRIS IVA MYRTLE CULP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 220 HUNTER'S VIEW LANE, CENTREVILLE, MD 21617 VIRGINIA LEE MARTIN/DAUGHTER other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Department of Important: If it any injury or o once. OCTOBER 1 X Burial 2 Cremation 3 Removal from State CHESTERFIELD CEMETERY CENTREVILLE, MD 4 Donation 5 Other (Specify) 2011 21. Signature of Funeral Service Licensee FELLOWS Add HELFENBEIN & NEWNAM FUNERAL HOME, 408 SOUTH LIBERTY ST., CENTREVILLE, MD 21617 23at Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ anciente disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to mimediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). and -transit Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Pregnant at time of death Year Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 XNo Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Sp this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 L 3 L Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date sitned (Month. Day, Year) 10 2011 MON. D.O. H0057*021* 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

VALERIE

31. Date filed (Month,

32. Regis rar's Signature

GOODMAN